

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

OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION
AND SETTLEMENT SUMMARY

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019

Worksheet S
Parts I-III
Date/Time Prepared:
2/28/2020 3:09 pm

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 2/28/2020	Time: 3:09 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by OSF SAINT LUKE MEDICAL CENTER (14-1325) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-10,262	-295,670	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	11,807	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC KEWANEE I	0		-161,020		0	10.00
10.01	RURAL HEALTH CLINIC II GALVA	0		11,350		0	10.01
10.02	RURAL HEALTH CLINIC III SHEFFIELD	0		4,451		0	10.02
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	1,545	-440,889	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1325		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/28/2020 3:09 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1051 WEST SOUTH STREET			PO Box: 747				1.00	
2.00	City: KEWANEE			State: IL		Zip Code: 61443		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
Hospital and Hospital-Based Component Identification:									
3.00	Hospital		OSF SAINT LUKE MEDICAL CENTER	141325	19340	1	07/01/1966	N	O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF		OSF SAINT LUKE SWING BED	14Z325	19340		03/19/2003	N	O
8.00	Swing Beds - NF		OSF SAINT LUKE SWING BED	14Z325	19340		03/19/2003	N	N
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC		FAMILY HEALTH CLINIC	143445	19340		10/01/1998	N	O
15.01	Hospital-Based Health Clinic - RHC		OSF MEDICAL GROUP GALVA II	148595	19340		01/09/2019	N	O
15.02	Hospital-Based Health Clinic - RHC		OSF MEDICAL GROUP SHEFFIELD	148594	19340		12/13/2018	N	O
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2018	09/30/2019	
21.00	Type of Control (see instructions)						1		
							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			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	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	
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.					0	N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/28/2020 3:09 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1325		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/28/2020 3:09 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		N			60.00	
			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
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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To 09/30/2019Worksheet S-2
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		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.	N	N		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.	N	N		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.	N	N		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.	N	N		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.	N	N		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00

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		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 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	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N					111.00
						1.00	
						2.00	
						3.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1					118.00
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	9,964		0		23,876	
						1.00	
						2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N					118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N				N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y					121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N					122.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N					125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
All Providers							

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1325	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/28/2020 3:09 pm	
		1.00	2.00		
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)	Y	149006	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: OSF HEALTHCARE SYSTEM	Contractor's Name: WPS		Contractor's Number: 00131	
142.00	Street: 800 N.E. GLEN OAK AVENUE	PO Box:			
143.00	City: PEORIA	State: IL		Zip Code: 61603	
		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.	Y		08/29/2019	
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.			146.00	
		1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	Y		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 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	Y	Y	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
		1.00			
Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N		165.00	
		Name 0	County 1.00	State 2.00	Zip Code 3.00
				CBSA 4.00	FTE/Campus 5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)				0.00
		1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act					
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00		169.00	
		Beginning 1.00		Ending 2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1325	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/28/2020 3:09 pm
		1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1325		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part II Date/Time Prepared: 2/28/2020 3:09 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			Y			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	12/13/2019	Y	12/31/2019
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: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/28/2020 3:09 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		Y		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.		N		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.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		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.		Y		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.	REBECCA	ROBINSON		41.00
42.00	Enter the employer/company name of the cost report preparer.	OSF HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	309-624-7644	REBECCA.C.ROBINSON@OSFHEALTHCARE.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/28/2020 3:09 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	GOVT REPORTING ANALYST	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: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/28/2020 3:09 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	8,030	24,124.98	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)		22	8,030	24,124.98	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	3	1,095	284.59	0	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)		25	9,125	24,409.57	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						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
26.00 RURAL HEALTH CLINIC KEWANEE	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II GALVA	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III SHEFFIELD	88.02				0	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/28/2020 3:09 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	604	31	995		1.00
2.00	HMO and other (see instructions)	181	0			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	273	0	448		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	17		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	877	31	1,460		7.00
8.00	INTENSIVE CARE UNIT	12	4	21		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)	889	35	1,481	0.00	14.00
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					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
26.00	RURAL HEALTH CLINIC KEWANEE	3,762	6,509	16,402	0.00	34.11
26.01	RURAL HEALTH CLINIC II GALVA	477	1,117	4,156	0.00	4.70
26.02	RURAL HEALTH CLINIC III SHEFFIELD	494	1,505	5,153	0.00	6.08
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	205.86
28.00	Observation Bed Days		96	595		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/28/2020 3:09 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	242	20	553	1.00
2.00 HMO and other (see instructions)			73	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	242	20	553	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						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
26.00 RURAL HEALTH CLINIC KEWANEE	0.00					26.00
26.01 RURAL HEALTH CLINIC II GALVA	0.00					26.01
26.02 RURAL HEALTH CLINIC III SHEFFIELD	0.00					26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1325 Component CCN: 14-3445		Period: From 10/01/2018 To 09/30/2019		Worksheet S-8 Date/Time Prepared: 2/28/2020 3:09 pm	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				1051 WEST SOUTH STREET				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				08:00		18:00		08:00
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?				N				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								14.00
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County				HENRY				2.00
				Tuesday	Wednesday		Thursday		
				to	from	to	from	to	
				6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)									
11.00	CLINIC				18:00		08:00		18:00

Health Financial Systems		OSF SAINT LUKE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1325	Period: From 10/01/2018	Worksheet S-8
			Component CCN: 14-3445	To 09/30/2019	Date/Time Prepared: 2/28/2020 3:09 pm
			RHC I		Cost
			Friday		Saturday
			from	to	from
			11.00	12.00	13.00
					14.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	17:00	08:00	12:00
					11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1325 Component CCN: 14-8595		Period: From 10/01/2018 To 09/30/2019		Worksheet S-8 Date/Time Prepared: 2/28/2020 3:09 pm	
				RHC II		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				230 S EXCHANGE ST		1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County				GALVA IL 61434		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
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?				N		0		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.								13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								14.00
				Y/N		V		Total Visits	
				1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County								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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1325 Component CCN: 14-8595	Period: From 10/01/2018 To 09/30/2019	Worksheet S-8 Date/Time Prepared: 2/28/2020 3:09 pm	
			RHC II		Cost	
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC	08:00	16:30			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1325 Component CCN: 14-8594		Period: From 10/01/2018 To 09/30/2019		Worksheet S-8 Date/Time Prepared: 2/28/2020 3:09 pm	
				RHC III		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				113 S MAIN ST				1.00
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County				SHEFFIELD IL 61361				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				07:45		17:00		07:45
						1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?								12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								14.00
				Y/N		V		Total Visits	
				1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County								2.00
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)									
11.00	CLINIC				17:00		08:00		17:00
						07:45		17:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1325 Component CCN: 14-8594		Period: From 10/01/2018 To 09/30/2019	Worksheet S-8 Date/Time Prepared: 2/28/2020 3:09 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	07:45	17:00			11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1325	Period: From 10/01/2018 To 09/30/2019	Worksheet S-10 Date/Time Prepared: 2/28/2020 3:09 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)			0.360782 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	6,786,783		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	20,603,772		6.00
7.00	Medicaid cost (line 1 times line 6)	7,433,470		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)	646,687		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)	646,687		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)	1,678,673	282,157	1,960,830 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	605,635	282,157	887,792 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)	605,635	282,157	887,792 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,828,097		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	511,036		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	786,209		27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,041,888		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,011,849		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,899,641		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,546,328		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		528,360	528,360	28,545	556,905	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		457,124	457,124	0	457,124	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,027,901	3,027,901	1,029,292	4,057,193	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	980,249	5,804,675	6,784,924	-654,616	6,130,308	5.00
7.00	00700	OPERATION OF PLANT	295,499	1,328,930	1,624,429	-309,419	1,315,010	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	142,294	142,294	8.00
9.00	00900	HOUSEKEEPING	264,315	180,795	445,110	-142,438	302,672	9.00
10.00	01000	DIETARY	257,655	145,580	403,235	-330,033	73,202	10.00
11.00	01100	CAFETERIA	0	0	0	326,057	326,057	11.00
13.00	01300	NURSING ADMINISTRATION	28,665	861	29,526	0	29,526	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	75,726	4,815	80,541	0	80,541	14.00
15.00	01500	PHARMACY	177,584	676,512	854,096	40,977	895,073	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	207,335	8,011	215,346	0	215,346	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	233,666	233,666	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,306,317	758,147	2,064,464	-51,909	2,012,555	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	19,051	19,051	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	728,330	393,302	1,121,632	162,415	1,284,047	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	414,084	20,858	434,942	0	434,942	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	238,713	15,406	254,119	336,696	590,815	54.00
54.01	03440	MAMMOGRAPHY	108,102	11,864	119,966	-1,704	118,262	54.01
56.00	05600	RADIOISOTOPE	0	181,878	181,878	1,697	183,575	56.00
56.01	03630	ULTRA SOUND	332,907	5,920	338,827	-106,711	232,116	56.01
57.00	05700	CT SCAN	302,547	141,800	444,347	1,697	446,044	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	171,119	9,094	180,213	1,697	181,910	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	697,875	488,345	1,186,220	45,964	1,232,184	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	33,891	33,891	10,826	44,717	62.00
65.00	06500	RESPIRATORY THERAPY	192,065	43,203	235,268	0	235,268	65.00
66.00	06600	PHYSICAL THERAPY	613,170	20,226	633,396	22,865	656,261	66.00
67.00	06700	OCCUPATIONAL THERAPY	167,629	2,575	170,204	6,144	176,348	67.00
68.00	06800	SPEECH PATHOLOGY	54,179	856	55,035	1,987	57,022	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	206,543	2,539	209,082	0	209,082	69.01
69.02	03650	VASCULAR LAB	0	0	0	108,408	108,408	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	39,000	39,000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	425,579	425,579	0	425,579	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC KEWANEE	3,090,922	1,847,739	4,938,661	-765,718	4,172,943	88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	350,927	338,867	689,794	-226,466	463,328	88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	611,045	771,783	1,382,828	-341,253	1,041,575	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,228,397	2,568,961	3,797,358	-2,900	3,794,458	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,101,899	20,246,397	33,348,296	-373,889	32,974,407	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,162	45,673	57,835	0	57,835	190.00
190.01	19001	FOUNDATION	12,162	25,436	37,598	0	37,598	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,790	12,790	373,889	386,679	192.00
194.00	07950	INDUSTRIAL MEDICINE	65	60	125	0	125	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	13,126,288	20,330,356	33,456,644	0	33,456,644	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/28/2020 3:09 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	958,353	1,515,258	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	880,752	1,337,876	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-103,781	3,953,412	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-755,951	5,374,357	5.00
7.00	00700	OPERATION OF PLANT	-9,368	1,305,642	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	142,294	8.00
9.00	00900	HOUSEKEEPING	0	302,672	9.00
10.00	01000	DIETARY	0	73,202	10.00
11.00	01100	CAFETERIA	-124,175	201,882	11.00
13.00	01300	NURSING ADMINISTRATION	188,595	218,121	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	80,541	14.00
15.00	01500	PHARMACY	-8,181	886,892	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,166	211,180	16.00
17.00	01700	SOCIAL SERVICE	-36,907	196,759	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-668,502	1,344,053	30.00
31.00	03100	INTENSIVE CARE UNIT	0	19,051	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-162,864	1,121,183	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-415,692	19,250	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	590,815	54.00
54.01	03440	MAMMOGRAPHY	0	118,262	54.01
56.00	05600	RADIOISOTOPE	0	183,575	56.00
56.01	03630	ULTRA SOUND	0	232,116	56.01
57.00	05700	CT SCAN	0	446,044	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	181,910	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-25,047	1,207,137	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	44,717	62.00
65.00	06500	RESPIRATORY THERAPY	0	235,268	65.00
66.00	06600	PHYSICAL THERAPY	-69,875	586,386	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	176,348	67.00
68.00	06800	SPEECH PATHOLOGY	0	57,022	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	209,082	69.01
69.02	03650	VASCULAR LAB	0	108,408	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	39,000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-425,579	0	73.00
73.01	03480	ONCOLOGY	0	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC KEWANEE	-10,244	4,162,699	88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	-1,761	461,567	88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	-61,613	979,962	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	09100	EMERGENCY	-1,982,608	1,811,850	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,838,614	30,135,793	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	57,835	190.00
190.01	19001	FOUNDATION	0	37,598	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	386,679	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	125	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,838,614	30,618,030	200.00

RECLASSIFICATIONS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
2/28/2020 3:09 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - LAUNDRY EXPENSES					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	142,294		1.00
	0		0	142,294		
	B - CLINICAL ENGINEERING					
1.00	LABORATORY	60.00	0	57,431		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	341,780		2.00
	0		0	399,211		
	C - CAFETERIA					
1.00	CAFETERIA	11.00	210,415	115,642		1.00
	0		210,415	115,642		
	D - BLOOD COSTS					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	10,826	0		1.00
	0		10,826	0		
	F - RADIOLOGY SERVICES					
1.00	RADIOISOTOPE	56.00	0	1,697		1.00
2.00	ULTRA SOUND	56.01	0	1,697		2.00
3.00	CT SCAN	57.00	0	1,697		3.00
4.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,697		4.00
	TOTALS		0	6,788		
	G - VASCULAR LAB SERVICES					
1.00	VASCULAR LAB	69.02	108,408	0		1.00
	0		108,408	0		
	H - MINISTRY ALLOCATIONS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	414,889		1.00
2.00	OPERATION OF PLANT	7.00	0	74,442		2.00
3.00	PHARMACY	15.00	0	40,977		3.00
4.00	PHYSICAL THERAPY	66.00	0	22,865		4.00
5.00	OCCUPATIONAL THERAPY	67.00	0	6,144		5.00
6.00	SPEECH PATHOLOGY	68.00	0	1,987		6.00
7.00	SOCIAL SERVICE	17.00	0	233,666		7.00
	0		0	794,970		
	I - OTHER THERAPUTIC SERVICES					
1.00	OPERATING ROOM	50.00	28,589	0		1.00
	0		28,589	0		
	J - SURGEON RHC					
1.00	OPERATING ROOM	50.00	168,523	4,303		1.00
	0		168,523	4,303		
	K - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	39,000		1.00
	0		0	39,000		
	L - ICU COSTS					
1.00	INTENSIVE CARE UNIT	31.00	17,762	1,289		1.00
	0		17,762	1,289		
	P - RHC NRCC PORTION					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	259,506	114,383		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	15,535		2.00
	TOTALS		259,506	129,918		
	Q - RHC SHARED BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	769,215		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	769,215		
	R - REPAIRS AND MAINTENANCE					
1.00	OPERATION OF PLANT	7.00	0	15,350		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
	TOTALS		0	15,350		
	S - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	28,545		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	141,802		2.00
	TOTALS		0	170,347		
500.00	Grand Total: Increases		804,029	2,588,327		500.00

RECLASSIFICATIONS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet A-6
Date/Time Prepared:
2/28/2020 3:09 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LAUNDRY EXPENSES						
1.00	HOUSEKEEPING	9.00	0	142,294	0		1.00
	0		0	142,294			
	B - CLINICAL ENGINEERING						
1.00	OPERATION OF PLANT	7.00	0	399,211	0		1.00
2.00	0	0.00	0	0	0		2.00
	0		0	399,211			
	C - CAFETERIA						
1.00	DIETARY	10.00	210,415	115,642	0		1.00
	0		210,415	115,642			
	D - BLOOD COSTS						
1.00	LABORATORY	60.00	10,826	0	0		1.00
	0		10,826	0			
	F - RADIOLOGY SERVICES						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,084	0		1.00
2.00	MAMMOGRAPHY	54.01	0	1,704	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	6,788			
	G - VASCULAR LAB SERVICES						
1.00	ULTRA SOUND	56.01	108,408	0	0		1.00
	0		108,408	0			
	H - MINISTRY ALLOCATIONS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	794,970	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
	0		0	794,970			
	I - OTHER THERAPUTIC SERVICES						
1.00	ADULTS & PEDIATRICS	30.00	28,589	0	0		1.00
	0		28,589	0			
	J - SURGEON RHC						
1.00	RURAL HEALTH CLINIC KEWANEE	88.00	168,523	4,303	0		1.00
	0		168,523	4,303			
	K - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	39,000	0		1.00
	0		0	39,000			
	L - ICU COSTS						
1.00	ADULTS & PEDIATRICS	30.00	17,762	1,289	0		1.00
	0		17,762	1,289			
	P - RHC NRCC PORTION						
1.00	RURAL HEALTH CLINIC II GALVA	88.01	0	162,438	0		1.00
2.00	RURAL HEALTH CLINIC III	88.02	0	226,986	0		2.00
	SHEFFIELD						
	TOTALS		0	389,424			
	Q - RHC SHARED BENEFITS						
1.00	RURAL HEALTH CLINIC KEWANEE	88.00	0	592,892	0		1.00
2.00	RURAL HEALTH CLINIC II GALVA	88.01	0	63,221	0		2.00
3.00	RURAL HEALTH CLINIC III	88.02	0	113,102	0		3.00
	SHEFFIELD						
	TOTALS		0	769,215			
	R - REPAIRS AND MAINTENANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,448	0		1.00
2.00	HOUSEKEEPING	9.00	0	144	0		2.00
3.00	DIETARY	10.00	0	3,976	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	4,269	0		4.00
5.00	LABORATORY	60.00	0	641	0		5.00
6.00	RURAL HEALTH CLINIC II GALVA	88.01	0	807	0		6.00
7.00	RURAL HEALTH CLINIC III	88.02	0	1,165	0		7.00
	SHEFFIELD						
8.00	EMERGENCY	91.00	0	2,900	0		8.00
	TOTALS		0	15,350			
	S - INSURANCE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	170,347	12		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	170,347			
500.00	Grand Total: Decreases		544,523	2,847,833			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part I
Date/Time Prepared:
2/28/2020 3:09 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,740,612	0	0	0	28,594	1.00
2.00	Land Improvements	1,321,467	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,950,334	336,838	0	336,838	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	10,801,924	500,503	0	500,503	1,023,164	6.00
7.00	HIT designated Assets	4,714,976	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	38,529,313	837,341	0	837,341	1,051,758	8.00
9.00	Reconciling Items	120,968	164,528	0	164,528	0	9.00
10.00	Total (line 8 minus line 9)	38,408,345	672,813	0	672,813	1,051,758	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,712,018	0				1.00
2.00	Land Improvements	1,321,467	0				2.00
3.00	Buildings and Fixtures	20,287,172	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	10,279,263	0				6.00
7.00	HIT designated Assets	4,714,976	0				7.00
8.00	Subtotal (sum of lines 1-7)	38,314,896	0				8.00
9.00	Reconciling Items	285,496	0				9.00
10.00	Total (line 8 minus line 9)	38,029,400	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part II
Date/Time Prepared:
2/28/2020 3:09 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	528,360	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	457,124	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	985,484	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	528,360				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	457,124				2.00
3.00	Total (sum of lines 1-2)	0	985,484				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part III
Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	23,320,657	0	23,320,657	0.608658	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,994,239	0	14,994,239	0.391342	0	2.00
3.00	Total (sum of lines 1-2)	38,314,896	0	38,314,896	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,374,825	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,230,574	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,605,399	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	111,888	28,545	0	0	1,515,258	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	107,302	0	0	0	1,337,876	2.00
3.00	Total (sum of lines 1-2)	219,190	28,545	0	0	2,853,134	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-12,135	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,368	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,659,465			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	892,973			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-124,175	CAFETERIA	11.00	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	-4,166	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	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: 14-1325

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
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	A	-38,896	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISC INC	B	-8,762	RURAL HEALTH CLINIC KEWANEE	88.00	0	33.00
33.01	MISC INC	B	-49,710	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISC INC	B	-27,552	PHYSICAL THERAPY	66.00	0	33.02
33.03	MISC INC	B	-8,181	PHARMACY	15.00	0	33.03
33.04	MISC INC	B	-120	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	MISC INC	B	-1,240	RURAL HEALTH CLINIC II GALVA	88.01	0	33.05
33.06	MISC INC	B	-61,509	RURAL HEALTH CLINIC III SHEFFIELD	88.02	0	33.06
33.07	MISC INC	B	-130	LABORATORY	60.00	0	33.07
33.08	PROVIDER TAX	A	-876,369	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	PATIENT PHONE - SALARIES	A	-1,496	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	PATIENT PHONE - BENEF	A	-324	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	CRNA - SALARY	A	-414,084	ANESTHESIOLOGY	53.00	0	33.11
33.12	CRNA - BENEFITS	A	-89,609	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	CRNA - OTHER EXPENSE	A	-1,608	ANESTHESIOLOGY	53.00	0	33.13
33.14	LOBBYING	A	-12,794	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	REAL ESTATE TAXES	A	-22,546	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	IMPAIRMENT OF ASSETS	A	413,833	CAP REL COSTS-BLDG & FIXT	1.00	9	33.16
33.17	IMPAIRMENT OF ASSETS	A	-38,200	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.17
33.18	PATIENT TRANSPORTATION	A	-178,214	EMERGENCY	91.00	0	33.18
33.19	NONALLOWABLE FAMILY PRACTICE COSTS	A	-1,482	RURAL HEALTH CLINIC KEWANEE	88.00	0	33.19
33.20	NONALLOWABLE FAMILY PRACTICE COSTS	A	-521	RURAL HEALTH CLINIC II GALVA	88.01	0	33.20
33.21	NONALLOWABLE FAMILY PRACTICE COSTS	A	-104	RURAL HEALTH CLINIC III SHEFFIELD	88.02	0	33.21
33.22	TV DEPRECIATION	A	-51	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.22
33.23	TV EXPENSE	A	-1,092	ADULTS & PEDIATRICS	30.00	0	33.23
33.24	RE-LIFING OFFSET	A	602,695	CAP REL COSTS-BLDG & FIXT	1.00	9	33.24
33.25	RE-LIFING OFFSET	A	377,538	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.25
33.26	340B OFFSET	A	-425,579	DRUGS CHARGED TO PATIENTS	73.00	0	33.26
33.27	SPORTSCARE SALARIES	A	-40,954	PHYSICAL THERAPY	66.00	0	33.27
33.28	SPORTSCARE EXPENSES	A	-1,369	PHYSICAL THERAPY	66.00	0	33.28
33.29	SPORTSCARE BENEFITS	A	-8,862	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.29
33.30	PHYSICIAN BENEFITS	A	-4,986	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.30
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,838,614				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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-1

Date/Time Prepared:
2/28/2020 3:09 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL BLDG HO BLDG CAPITA	98,050	268,113	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	473,059	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HO POOLED - ADMIN & GENERAL	1,403,444	2,701,711	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	MINISTRY ALLOCATION	414,889	414,889	3.01
3.02	7.00	OPERATION OF PLANT	MINISTRY ALLOCATION	313,356	313,356	3.02
3.03	30.00	ADULTS & PEDIATRICS	MINISTRY ALLOCATION	2,888	2,888	3.03
3.04	66.00	PHYSICAL THERAPY	MINISTRY ALLOCATION	22,865	22,865	3.04
3.05	67.00	OCCUPATIONAL THERAPY	MINISTRY ALLOCATION	6,144	6,144	3.05
3.06	68.00	SPEECH PATHOLOGY	MINISTRY ALLOCATION	1,987	1,987	3.06
3.07	15.00	PHARMACY	MINISTRY ALLOCATION	40,977	40,977	3.07
3.08	73.00	DRUGS CHARGED TO PATIENTS	MINISTRY ALLOCATION	164,661	164,661	3.08
3.09	54.00	RADIOLOGY-DIAGNOSTIC	MINISTRY ALLOCATION	341,780	341,780	3.09
3.10	60.00	LABORATORY	MINISTRY ALLOCATION	57,431	57,431	3.10
4.00	1.00	CAP REL COSTS-BLDG & FIXT	HO INTEREST (OPERATING)	124,023	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	HO INTEREST (OPERATING)	107,302	0	4.01
4.02	13.00	NURSING ADMINISTRATION	HO FUNCTIONAL - NURSING ADMI	188,595	0	4.02
4.03	17.00	SOCIAL SERVICE	HO FUNCTIONAL - SOCIAL SERVI	196,759	233,666	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	HO FUNCTIONAL - ADMIN & GEN	2,457,818	922,396	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY SFI	211,280	241,471	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,627,308	5,734,335	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B		0.00	OSF HEALTHCARE	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-1

Date/Time Prepared:
2/28/2020 3:09 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-170,063	9		1.00
2.00	473,059	9		2.00
3.00	-1,298,267	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
4.00	124,023	11		4.00
4.01	107,302	11		4.01
4.02	188,595	0		4.02
4.03	-36,907	0		4.03
4.04	1,535,422	0		4.04
4.05	-30,191	0		4.05
5.00	892,973			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-2

Date/Time Prepared:
2/28/2020 3:09 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	30.00	ADULTS & PEDIATRICS	667,290	667,290	0	0	0	1.00
2.00	50.00	OPERATING ROOM	172,176	162,864	9,312	0	0	2.00
3.00	60.00	LABORATORY	24,917	24,917	0	0	0	3.00
4.00	91.00	EMERGENCY	2,219,427	1,804,394	415,033	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,083,810	2,659,465	424,345		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	667,290		1.00
2.00	50.00	OPERATING ROOM	0	0	0	162,864		2.00
3.00	60.00	LABORATORY	0	0	0	24,917		3.00
4.00	91.00	EMERGENCY	0	0	0	1,804,394		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,659,465		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,515,258	1,515,258			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,337,876		1,337,876		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,953,412	0	87	3,953,499	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,374,357	242,853	161,357	299,818	5.00
7.00	00700	OPERATION OF PLANT	1,305,642	125,742	65,027	90,519	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	142,294	6,403	0	0	8.00
9.00	00900	HOUSEKEEPING	302,672	12,311	0	80,966	9.00
10.00	01000	DIETARY	73,202	34,274	10,044	14,471	10.00
11.00	01100	CAFETERIA	201,882	11,693	0	64,455	11.00
13.00	01300	NURSING ADMINISTRATION	218,121	4,454	0	8,781	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	80,541	0	0	23,197	14.00
15.00	01500	PHARMACY	886,892	21,050	42,424	54,398	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	211,180	29,123	458	63,512	16.00
17.00	01700	SOCIAL SERVICE	196,759	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,344,053	279,245	58,406	378,901	30.00
31.00	03100	INTENSIVE CARE UNIT	19,051	39,470	0	5,441	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,121,183	148,245	130,988	283,486	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	19,250	2,088	37,923	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	590,815	70,666	569,039	73,124	54.00
54.01	03440	MAMMOGRAPHY	118,262	2,676	0	33,114	54.01
56.00	05600	RADIOISOTOPE	183,575	4,176	0	0	56.00
56.01	03630	ULTRA SOUND	232,116	3,619	3,647	68,770	56.01
57.00	05700	CT SCAN	446,044	5,846	0	92,678	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	181,910	29,108	0	52,418	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	1,207,137	30,562	135,395	210,460	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	44,717	2,784	0	3,316	62.00
65.00	06500	RESPIRATORY THERAPY	235,268	8,630	5,533	58,834	65.00
66.00	06600	PHYSICAL THERAPY	586,386	52,091	1,707	175,284	66.00
67.00	06700	OCCUPATIONAL THERAPY	176,348	4,733	0	51,349	67.00
68.00	06800	SPEECH PATHOLOGY	57,022	1,670	1,480	16,596	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	209,082	31,304	74,428	63,269	69.01
69.02	03650	VASCULAR LAB	108,408	1,670	0	33,208	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC KEWANEE	4,162,699	145,137	9,061	895,204	88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	461,567	0	0	107,498	88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	979,962	0	0	187,178	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,811,850	109,239	18,906	376,289	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,135,793	1,460,862	1,325,910	3,866,534	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	57,835	14,152	0	3,726	190.00
190.01	19001	FOUNDATION	37,598	0	9,240	3,726	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	2,726	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	386,679	40,244	0	79,493	192.00
194.00	07950	INDUSTRIAL MEDICINE	125	0	0	20	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	30,618,030	1,515,258	1,337,876	3,953,499	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
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
5.00	00500	ADMINISTRATIVE & GENERAL	6,078,385					5.00
7.00	00700	OPERATION OF PLANT	393,078	1,980,008				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	36,832	11,057	196,586			8.00
9.00	00900	HOUSEKEEPING	98,075	21,259	21,210	536,493		9.00
10.00	01000	DIETARY	32,694	59,182	0	4,357	228,224	10.00
11.00	01100	CAFETERIA	68,867	20,190	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	57,306	7,692	0	7,956	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	25,696	0	0	7,956	0	14.00
15.00	01500	PHARMACY	248,877	36,348	0	12,124	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	75,368	50,289	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	48,737	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	510,406	482,191	53,268	217,290	224,988	30.00
31.00	03100	INTENSIVE CARE UNIT	15,843	68,155	0	5,115	3,236	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	417,097	255,984	13,807	64,220	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	14,679	3,605	0	947	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	322,909	122,023	15,253	43,192	0	54.00
54.01	03440	MAMMOGRAPHY	38,158	4,620	0	0	0	54.01
56.00	05600	RADIOISOTOPE	46,505	7,211	0	2,463	0	56.00
56.01	03630	ULTRA SOUND	76,328	6,249	0	2,273	0	56.01
57.00	05700	CT SCAN	134,888	10,095	0	5,304	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	65,252	50,262	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	392,242	52,772	0	26,522	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	12,587	4,807	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	76,356	14,902	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	201,989	89,948	20,686	23,869	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	57,572	8,172	0	6,630	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,015	2,884	0	5,304	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	93,650	54,054	10,430	12,882	0	69.01
69.02	03650	VASCULAR LAB	35,492	2,884	0	4,736	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,660	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC KEWANEE	1,291,009	250,616	0	21,596	0	88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	140,956	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	289,097	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	573,737	188,629	61,932	52,664	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,920,957	1,886,080	196,586	527,400	228,224	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,754	24,437	0	0	0	190.00
190.01	19001	FOUNDATION	12,525	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	675	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	125,438	69,491	0	9,093	0	192.00
194.00	07950	INDUSTRIAL MEDICINE	36	0	0	0	0	194.00
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)	6,078,385	1,980,008	196,586	536,493	228,224	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	367,087					11.00
13.00	01300	NURSING ADMINISTRATION	932	305,242				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,849	0	142,239			14.00
15.00	01500	PHARMACY	4,913	11,226	5,215	1,323,467		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,357	0	111	0	444,398	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	44,150	100,892	25,260	0	15,417	30.00
31.00	03100	INTENSIVE CARE UNIT	614	1,403	0	0	379	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	38,432	87,827	52,024	0	44,948	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4,023	0	1,079	0	8,095	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,364	0	515	0	19,156	54.00
54.01	03440	MAMMOGRAPHY	3,684	0	45	0	4,216	54.01
56.00	05600	RADIOISOTOPE	0	0	282	0	5,043	56.00
56.01	03630	ULTRA SOUND	5,929	0	248	0	8,397	56.01
57.00	05700	CT SCAN	9,973	0	1,435	0	52,745	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,273	0	137	0	19,275	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	26,003	0	5,040	0	87,592	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	402	0	0	0	1,380	62.00
65.00	06500	RESPIRATORY THERAPY	9,042	0	2,706	0	9,068	65.00
66.00	06600	PHYSICAL THERAPY	20,243	0	248	0	15,815	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,044	0	0	0	3,405	67.00
68.00	06800	SPEECH PATHOLOGY	1,715	0	1	0	584	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	8,364	0	311	0	14,617	69.01
69.02	03650	VASCULAR LAB	3,282	0	0	0	3,595	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,146	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,323,467	24,707	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC KEWANEE	72,228	0	6,244	0	30,711	88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	9,952	0	45	0	7,592	88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	12,874	0	484	0	10,160	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	45,462	103,894	40,692	0	55,355	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	359,104	305,242	142,122	1,323,467	444,398	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	699	0	0	0	0	190.00
190.01	19001	FOUNDATION	699	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,585	0	109	0	0	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	0	8	0	0	194.00
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)	367,087	305,242	142,239	1,323,467	444,398	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	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
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
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	245,496				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	242,015	3,976,482	0	3,976,482	30.00
31.00	03100	INTENSIVE CARE UNIT	3,481	162,188	0	162,188	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,658,241	0	2,658,241	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	91,689	0	91,689	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,835,056	0	1,835,056	54.00
54.01	03440	MAMMOGRAPHY	0	204,775	0	204,775	54.01
56.00	05600	RADIOISOTOPE	0	249,255	0	249,255	56.00
56.01	03630	ULTRA SOUND	0	407,576	0	407,576	56.01
57.00	05700	CT SCAN	0	759,008	0	759,008	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	403,635	0	403,635	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	2,173,725	0	2,173,725	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	69,993	0	69,993	62.00
65.00	06500	RESPIRATORY THERAPY	0	420,339	0	420,339	65.00
66.00	06600	PHYSICAL THERAPY	0	1,188,266	0	1,188,266	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	312,253	0	312,253	67.00
68.00	06800	SPEECH PATHOLOGY	0	106,271	0	106,271	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	572,391	0	572,391	69.01
69.02	03650	VASCULAR LAB	0	193,275	0	193,275	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	50,806	0	50,806	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,348,174	0	1,348,174	73.00
73.01	03480	ONCOLOGY	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC KEWANEE	0	6,884,505	0	6,884,505	88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	0	727,610	0	727,610	88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	0	1,479,755	0	1,479,755	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	3,438,649	0	3,438,649	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	245,496	29,713,917	0	29,713,917	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	119,603	0	119,603	190.00
190.01	19001	FOUNDATION	0	63,788	0	63,788	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	3,401	0	3,401	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	717,132	0	717,132	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	189	0	189	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	245,496	30,618,030	0	30,618,030	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	87	87	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	242,853	161,357	404,210	5.00
7.00	00700	OPERATION OF PLANT	0	125,742	65,027	190,769	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,403	0	6,403	8.00
9.00	00900	HOUSEKEEPING	0	12,311	0	12,311	9.00
10.00	01000	DIETARY	0	34,274	10,044	44,318	10.00
11.00	01100	CAFETERIA	0	11,693	0	11,693	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,454	0	4,454	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	21,050	42,424	63,474	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,123	458	29,581	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	279,245	58,406	337,651	30.00
31.00	03100	INTENSIVE CARE UNIT	0	39,470	0	39,470	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	148,245	130,988	279,233	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,088	37,923	40,011	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	70,666	569,039	639,705	54.00
54.01	03440	MAMMOGRAPHY	0	2,676	0	2,676	54.01
56.00	05600	RADIOISOTOPE	0	4,176	0	4,176	56.00
56.01	03630	ULTRA SOUND	0	3,619	3,647	7,266	56.01
57.00	05700	CT SCAN	0	5,846	0	5,846	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	29,108	0	29,108	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	30,562	135,395	165,957	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	2,784	0	2,784	62.00
65.00	06500	RESPIRATORY THERAPY	0	8,630	5,533	14,163	65.00
66.00	06600	PHYSICAL THERAPY	0	52,091	1,707	53,798	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,733	0	4,733	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,670	1,480	3,150	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	31,304	74,428	105,732	69.01
69.02	03650	VASCULAR LAB	0	1,670	0	1,670	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC KEWANEE	0	145,137	9,061	154,198	88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	109,239	18,906	128,145	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,460,862	1,325,910	2,786,772	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,152	0	14,152	190.00
190.01	19001	FOUNDATION	0	0	9,240	9,240	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	2,726	2,726	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	40,244	0	40,244	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,515,258	1,337,876	2,853,134	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
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
5.00	00500	ADMINISTRATIVE & GENERAL	404,217					5.00
7.00	00700	OPERATION OF PLANT	26,140	216,911				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,449	1,211	10,063			8.00
9.00	00900	HOUSEKEEPING	6,522	2,329	1,086	22,250		9.00
10.00	01000	DIETARY	2,174	6,483	0	181	53,156	10.00
11.00	01100	CAFETERIA	4,580	2,212	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,811	843	0	330	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,709	0	0	330	0	14.00
15.00	01500	PHARMACY	16,550	3,982	0	503	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,012	5,509	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	3,241	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	33,942	52,824	2,727	9,013	52,402	30.00
31.00	03100	INTENSIVE CARE UNIT	1,054	7,466	0	212	754	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	27,737	28,043	707	2,663	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	976	395	0	39	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,474	13,368	781	1,791	0	54.00
54.01	03440	MAMMOGRAPHY	2,538	506	0	0	0	54.01
56.00	05600	RADIOISOTOPE	3,093	790	0	102	0	56.00
56.01	03630	ULTRA SOUND	5,076	685	0	94	0	56.01
57.00	05700	CT SCAN	8,970	1,106	0	220	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,339	5,506	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	26,084	5,781	0	1,100	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	837	527	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	5,078	1,633	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	13,432	9,854	1,059	990	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,829	895	0	275	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,265	316	0	220	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	6,228	5,922	534	534	0	69.01
69.02	03650	VASCULAR LAB	2,360	316	0	196	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	642	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC KEWANEE	85,853	27,455	0	896	0	88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	9,374	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	19,225	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	38,154	20,664	3,169	2,184	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	393,748	206,621	10,063	21,873	53,156	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,247	2,677	0	0	0	190.00
190.01	19001	FOUNDATION	833	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	45	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,342	7,613	0	377	0	192.00
194.00	07950	INDUSTRIAL MEDICINE	2	0	0	0	0	194.00
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)	404,217	216,911	10,063	22,250	53,156	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	18,486					11.00
13.00	01300	NURSING ADMINISTRATION	47	9,485				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	244	0	2,284			14.00
15.00	01500	PHARMACY	247	349	84	85,190		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	723	0	2	0	40,828	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,223	3,135	406	0	1,417	30.00
31.00	03100	INTENSIVE CARE UNIT	31	44	0	0	35	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,935	2,729	835	0	4,132	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	203	0	17	0	744	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	421	0	8	0	1,761	54.00
54.01	03440	MAMMOGRAPHY	186	0	1	0	388	54.01
56.00	05600	RADIOISOTOPE	0	0	5	0	464	56.00
56.01	03630	ULTRA SOUND	299	0	4	0	772	56.01
57.00	05700	CT SCAN	502	0	23	0	4,848	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	266	0	2	0	1,772	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,309	0	81	0	8,028	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	20	0	0	0	127	62.00
65.00	06500	RESPIRATORY THERAPY	455	0	43	0	834	65.00
66.00	06600	PHYSICAL THERAPY	1,019	0	4	0	1,454	66.00
67.00	06700	OCCUPATIONAL THERAPY	204	0	0	0	313	67.00
68.00	06800	SPEECH PATHOLOGY	86	0	0	0	54	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	421	0	5	0	1,344	69.01
69.02	03650	VASCULAR LAB	165	0	0	0	330	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	197	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	85,190	2,271	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC KEWANEE	3,640	0	100	0	2,823	88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	501	0	1	0	698	88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	648	0	8	0	934	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	2,289	3,228	653	0	5,088	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,084	9,485	2,282	85,190	40,828	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	35	0	0	0	0	190.00
190.01	19001	FOUNDATION	35	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	332	0	2	0	0	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,486	9,485	2,284	85,190	40,828	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	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
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
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	3,241				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,195	498,944	0	498,944	30.00
31.00	03100	INTENSIVE CARE UNIT	46	49,112	0	49,112	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	348,020	0	348,020	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	42,385	0	42,385	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	679,311	0	679,311	54.00
54.01	03440	MAMMOGRAPHY	0	6,296	0	6,296	54.01
56.00	05600	RADIOISOTOPE	0	8,630	0	8,630	56.00
56.01	03630	ULTRA SOUND	0	14,198	0	14,198	56.01
57.00	05700	CT SCAN	0	21,517	0	21,517	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	40,994	0	40,994	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	208,345	0	208,345	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,295	0	4,295	62.00
65.00	06500	RESPIRATORY THERAPY	0	22,207	0	22,207	65.00
66.00	06600	PHYSICAL THERAPY	0	81,614	0	81,614	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,250	0	10,250	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,091	0	5,091	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	120,721	0	120,721	69.01
69.02	03650	VASCULAR LAB	0	5,038	0	5,038	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	839	0	839	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	87,461	0	87,461	73.00
73.01	03480	ONCOLOGY	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC KEWANEE	0	274,984	0	274,984	88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	0	10,576	0	10,576	88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	0	20,819	0	20,819	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	203,583	0	203,583	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,241	2,765,230	0	2,765,230	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,111	0	18,111	190.00
190.01	19001	FOUNDATION	0	10,108	0	10,108	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	2,771	0	2,771	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	56,912	0	56,912	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	2	0	2	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,241	2,853,134	0	2,853,134	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	97,971					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		925,609				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	60	12,906,224			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,702	111,635	978,757	-6,078,385	24,539,645	5.00
7.00	00700	OPERATION OF PLANT	8,130	44,989	295,499	0	1,586,930	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	0	0	0	148,697	8.00
9.00	00900	HOUSEKEEPING	796	0	264,315	0	395,949	9.00
10.00	01000	DIETARY	2,216	6,949	47,240	0	131,991	10.00
11.00	01100	CAFETERIA	756	0	210,415	0	278,030	11.00
13.00	01300	NURSING ADMINISTRATION	288	0	28,665	0	231,356	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	75,726	0	103,738	14.00
15.00	01500	PHARMACY	1,361	29,351	177,584	0	1,004,764	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,883	317	207,335	0	304,273	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	196,759	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,055	40,408	1,236,926	0	2,060,605	30.00
31.00	03100	INTENSIVE CARE UNIT	2,552	0	17,762	0	63,962	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,585	90,624	925,442	0	1,683,902	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	135	26,237	0	0	59,261	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,569	393,689	238,713	0	1,303,644	54.00
54.01	03440	MAMMOGRAPHY	173	0	108,102	0	154,052	54.01
56.00	05600	RADIOISOTOPE	270	0	0	0	187,751	56.00
56.01	03630	ULTRA SOUND	234	2,523	224,499	0	308,152	56.01
57.00	05700	CT SCAN	378	0	302,547	0	544,568	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,882	0	171,119	0	263,436	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,976	93,673	687,049	0	1,583,554	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	180	0	10,826	0	50,817	62.00
65.00	06500	RESPIRATORY THERAPY	558	3,828	192,065	0	308,265	65.00
66.00	06600	PHYSICAL THERAPY	3,368	1,181	572,216	0	815,468	66.00
67.00	06700	OCCUPATIONAL THERAPY	306	0	167,629	0	232,430	67.00
68.00	06800	SPEECH PATHOLOGY	108	1,024	54,179	0	76,768	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	2,024	51,493	206,543	0	378,083	69.01
69.02	03650	VASCULAR LAB	108	0	108,408	0	143,286	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	39,000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC KEWANEE	9,384	6,269	2,922,399	0	5,212,101	88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	0	0	350,927	0	569,065	88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	0	0	611,045	0	1,167,140	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	7,063	13,080	1,228,397	0	2,316,284	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	94,454	917,330	12,622,329	-6,078,385	23,904,081	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	915	0	12,162	0	75,713	190.00
190.01	19001	FOUNDATION	0	6,393	12,162	0	50,564	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	1,886	0	0	2,726	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,602	0	259,506	0	506,416	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	0	65	0	145	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,515,258	1,337,876	3,953,499		6,078,385	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.466393	1.445401	0.306325		0.247697	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			87		404,217	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000007		0.016472	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
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: 14-1325

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
		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
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	74,139				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	20,261			8.00
9.00	00900	HOUSEKEEPING	796	2,186			9.00
10.00	01000	DIETARY	2,216	0	23	1,481	10.00
11.00	01100	CAFETERIA	756	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	288	0	42	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	42	0	14.00
15.00	01500	PHARMACY	1,361	0	64	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,883	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	18,055	5,490	1,147	1,460	30.00
31.00	03100	INTENSIVE CARE UNIT	2,552	0	27	21	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,585	1,423	339	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	135	0	5	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,569	1,572	228	0	54.00
54.01	03440	MAMMOGRAPHY	173	0	0	0	54.01
56.00	05600	RADIOISOTOPE	270	0	13	0	56.00
56.01	03630	ULTRA SOUND	234	0	12	0	56.01
57.00	05700	CT SCAN	378	0	28	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,882	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	1,976	0	140	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	180	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	558	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,368	2,132	126	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	306	0	35	0	67.00
68.00	06800	SPEECH PATHOLOGY	108	0	28	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	2,024	1,075	68	0	69.01
69.02	03650	VASCULAR LAB	108	0	25	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC KEWANEE	9,384	0	114	0	88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	09100	EMERGENCY	7,063	6,383	278	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,622	20,261	2,784	1,481	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	915	0	0	0	190.00
190.01	19001	FOUNDATION	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,602	0	48	0	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,980,008	196,586	536,493	228,224	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.706700	9.702680	189.439619	154.101283	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	216,911	10,063	22,250	53,156	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.925734	0.496668	7.856638	35.891965	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: 14-1325

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description			NURSING ADMINISTRATIO N (NURSING FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	6,308					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	347,501				14.00
15.00	01500	PHARMACY	232	12,741	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	270	0	82,359,709		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	1,481	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,085	61,711	0	2,857,024	1,460	30.00
31.00	03100	INTENSIVE CARE UNIT	29	0	0	70,308	21	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,815	127,099	0	8,329,811	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,636	0	1,500,135	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,257	0	3,550,097	0	54.00
54.01	03440	MAMMOGRAPHY	0	110	0	781,364	0	54.01
56.00	05600	RADIOISOTOPE	0	689	0	934,605	0	56.00
56.01	03630	ULTRA SOUND	0	607	0	1,556,075	0	56.01
57.00	05700	CT SCAN	0	3,506	0	9,774,858	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	334	0	3,572,015	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	12,314	0	16,235,522	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	255,815	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	6,610	0	1,680,572	0	65.00
66.00	06600	PHYSICAL THERAPY	0	607	0	2,930,867	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	631,004	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3	0	108,203	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	759	0	2,708,888	0	69.01
69.02	03650	VASCULAR LAB	0	0	0	666,291	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	397,706	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	4,578,717	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC KEWANEE	0	15,255	0	5,691,530	0	88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	0	110	0	1,406,907	0	88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	0	1,182	0	1,882,958	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	2,147	99,413	0	10,258,437	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,308	347,213	100	82,359,709	1,481	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1	0	0	0	190.00
190.01	19001	FOUNDATION	0	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	267	0	0	0	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	20	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	305,242	142,239	1,323,467	444,398	245,496	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	48.389664	0.409320	13,234.670000	0.005396	165.763673	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,485	2,284	85,190	40,828	3,241	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.503646	0.006573	851.900000	0.000496	2.188386	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description		NURSING ADMINISTRATIO N (NURSING FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	13.00	14.00	15.00	16.00	17.00	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/28/2020 3:09 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	3,976,482		3,976,482	0	0
31.00	03100	INTENSIVE CARE UNIT	162,188		162,188	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,658,241		2,658,241	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0
53.00	05300	ANESTHESIOLOGY	91,689		91,689	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,835,056		1,835,056	0	0
54.01	03440	MAMMOGRAPHY	204,775		204,775	0	0
56.00	05600	RADIOISOTOPE	249,255		249,255	0	0
56.01	03630	ULTRA SOUND	407,576		407,576	0	0
57.00	05700	CT SCAN	759,008		759,008	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	403,635		403,635	0	0
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0
60.00	06000	LABORATORY	2,173,725		2,173,725	0	0
60.01	06001	BLOOD LABORATORY	0		0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	69,993		69,993	0	0
65.00	06500	RESPIRATORY THERAPY	420,339	0	420,339	0	0
66.00	06600	PHYSICAL THERAPY	1,188,266	0	1,188,266	0	0
67.00	06700	OCCUPATIONAL THERAPY	312,253	0	312,253	0	0
68.00	06800	SPEECH PATHOLOGY	106,271	0	106,271	0	0
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0
69.01	03160	CARDIOPULMONARY	572,391		572,391	0	0
69.02	03650	VASCULAR LAB	193,275		193,275	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	50,806		50,806	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,348,174		1,348,174	0	0
73.01	03480	ONCOLOGY	0		0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC KEWANEE	6,884,505		6,884,505	0	0
88.01	08801	RURAL HEALTH CLINIC II GALVA	727,610		727,610	0	0
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	1,479,755		1,479,755	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0
91.00	09100	EMERGENCY	3,438,649		3,438,649	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,160,155		1,160,155	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	30,874,072	0	30,874,072	0	0
201.00		Less Observation Beds	1,160,155		1,160,155		0
202.00		Total (see instructions)	29,713,917	0	29,713,917	0	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/28/2020 3:09 pm

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,415,393		2,415,393		30.00
31.00	03100	INTENSIVE CARE UNIT	70,308		70,308		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	209,653	8,120,158	8,329,811	0.319124	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	65,091	1,435,044	1,500,135	0.061120	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	96,146	3,453,951	3,550,097	0.516903	54.00
54.01	03440	MAMMOGRAPHY	0	781,364	781,364	0.262074	54.01
56.00	05600	RADIOISOTOPE	23,756	910,849	934,605	0.266696	56.00
56.01	03630	ULTRA SOUND	11,507	1,544,568	1,556,075	0.261926	56.01
57.00	05700	CT SCAN	278,648	9,496,210	9,774,858	0.077649	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	88,891	3,483,124	3,572,015	0.112999	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	916,398	15,319,124	16,235,522	0.133887	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	51,866	203,949	255,815	0.273608	62.00
65.00	06500	RESPIRATORY THERAPY	227,883	1,452,689	1,680,572	0.250117	65.00
66.00	06600	PHYSICAL THERAPY	359,213	2,571,654	2,930,867	0.405432	66.00
67.00	06700	OCCUPATIONAL THERAPY	210,206	420,798	631,004	0.494851	67.00
68.00	06800	SPEECH PATHOLOGY	11,791	96,412	108,203	0.982145	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
69.01	03160	CARDIOPULMONARY	177,938	2,530,950	2,708,888	0.211301	69.01
69.02	03650	VASCULAR LAB	22,466	643,825	666,291	0.290076	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,734	386,972	397,706	0.127748	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,165,225	3,413,492	4,578,717	0.294444	73.00
73.01	03480	ONCOLOGY	0	0	0	0.000000	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC KEWANEE	0	5,691,530	5,691,530		88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	0	1,406,907	1,406,907		88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	0	1,882,958	1,882,958		88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	262,773	9,995,664	10,258,437	0.335202	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	54,731	386,900	441,631	2.626978	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	6,730,617	75,629,092	82,359,709		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	6,730,617	75,629,092	82,359,709		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-1325	Period: From 10/01/2018 To 09/30/2019	Worksheet C Part I Date/Time Prepared: 2/28/2020 3:09 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
31.00	03100	INTENSIVE CARE UNIT				31.00
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
54.01	03440	MAMMOGRAPHY	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
56.01	03630	ULTRA SOUND	0.000000			56.01
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
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
69.01	03160	CARDIOPULMONARY	0.000000			69.01
69.02	03650	VASCULAR LAB	0.000000			69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
73.01	03480	ONCOLOGY	0.000000			73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC KEWANEE				88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA				88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD				88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
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: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/28/2020 3:09 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	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	3,976,482		3,976,482	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	162,188		162,188	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,658,241		2,658,241	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	91,689		91,689	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,835,056		1,835,056	0	0	54.00
54.01	03440	MAMMOGRAPHY	204,775		204,775	0	0	54.01
56.00	05600	RADIOISOTOPE	249,255		249,255	0	0	56.00
56.01	03630	ULTRA SOUND	407,576		407,576	0	0	56.01
57.00	05700	CT SCAN	759,008		759,008	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	403,635		403,635	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	2,173,725		2,173,725	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	69,993		69,993	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	420,339	0	420,339	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,188,266	0	1,188,266	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	312,253	0	312,253	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	106,271	0	106,271	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	572,391		572,391	0	0	69.01
69.02	03650	VASCULAR LAB	193,275		193,275	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	50,806		50,806	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,348,174		1,348,174	0	0	73.00
73.01	03480	ONCOLOGY	0		0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC KEWANEE	6,884,505		6,884,505	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	727,610		727,610	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	1,479,755		1,479,755	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	3,438,649		3,438,649	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	29,713,917	0	29,713,917	0	0	200.00
201.00		Less Observation Beds	0		0			201.00
202.00		Total (see instructions)	29,713,917	0	29,713,917	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/28/2020 3:09 pm

			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0.000000	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	0	0	0	0.000000	0.000000	54.00
54.01	03440	MAMMOGRAPHY	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
56.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	56.01
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0.000000	0.000000	69.01
69.02	03650	VASCULAR LAB	0	0	0	0.000000	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	73.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC KEWANEE	0	0	0	0.000000	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	0	0	0	0.000000	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	0	0	0	0.000000	0.000000	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	0	0	0			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	0	0	0			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
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
54.01	03440	MAMMOGRAPHY	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
56.01	03630	ULTRA SOUND	0.000000		56.01
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
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
69.01	03160	CARDIOPULMONARY	0.000000		69.01
69.02	03650	VASCULAR LAB	0.000000		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
73.01	03480	ONCOLOGY	0.000000		73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC KEWANEE	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	0.000000		88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
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: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part II
Date/Time Prepared:
2/28/2020 3:09 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	348,020	8,329,811	0.041780	64,906	2,712	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	42,385	1,500,135	0.028254	18,696	528	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	679,311	3,550,097	0.191350	26,568	5,084	54.00	
54.01	03440	MAMMOGRAPHY	6,296	781,364	0.008058	0	0	54.01	
56.00	05600	RADIOISOTOPE	8,630	934,605	0.009234	10,003	92	56.00	
56.01	03630	ULTRA SOUND	14,198	1,556,075	0.009124	5,011	46	56.01	
57.00	05700	CT SCAN	21,517	9,774,858	0.002201	44,533	98	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	40,994	3,572,015	0.011476	57,310	658	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00	
60.00	06000	LABORATORY	208,345	16,235,522	0.012833	356,404	4,574	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,295	255,815	0.016789	23,369	392	62.00	
65.00	06500	RESPIRATORY THERAPY	22,207	1,680,572	0.013214	115,423	1,525	65.00	
66.00	06600	PHYSICAL THERAPY	81,614	2,930,867	0.027846	97,541	2,716	66.00	
67.00	06700	OCCUPATIONAL THERAPY	10,250	631,004	0.016244	53,535	870	67.00	
68.00	06800	SPEECH PATHOLOGY	5,091	108,203	0.047050	7,653	360	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00	
69.01	03160	CARDIOPULMONARY	120,721	2,708,888	0.044565	79,558	3,546	69.01	
69.02	03650	VASCULAR LAB	5,038	666,291	0.007561	9,678	73	69.02	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	839	397,706	0.002110	3,810	8	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	87,461	4,578,717	0.019102	448,512	8,567	73.00	
73.01	03480	ONCOLOGY	0	0	0.000000	0	0	73.01	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC KEWANEE	274,984	5,691,530	0.048315	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II GALVA	10,576	1,406,907	0.007517	0	0	88.01	
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	20,819	1,882,958	0.011057	0	0	88.02	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00	
91.00	09100	EMERGENCY	203,583	10,258,437	0.019845	1,389	28	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	145,569	441,631	0.329617	6,120	2,017	92.00	
200.00		Total (lines 50 through 199)	2,362,743	79,874,008		1,430,019	33,894	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03440	MAMMOGRAPHY	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	03630	ULTRA SOUND	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
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
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
69.02	03650	VASCULAR LAB	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC KEWANEE	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	0	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description			Title XVIII		Hospital	Cost	
			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)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	8,329,811	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	1,500,135	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,550,097	0.000000
54.01	03440	MAMMOGRAPHY	0	0	0	781,364	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	934,605	0.000000
56.01	03630	ULTRA SOUND	0	0	0	1,556,075	0.000000
57.00	05700	CT SCAN	0	0	0	9,774,858	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,572,015	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000
60.00	06000	LABORATORY	0	0	0	16,235,522	0.000000
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	255,815	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,680,572	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	2,930,867	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	631,004	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	108,203	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000
69.01	03160	CARDIOPULMONARY	0	0	0	2,708,888	0.000000
69.02	03650	VASCULAR LAB	0	0	0	666,291	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	397,706	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,578,717	0.000000
73.01	03480	ONCOLOGY	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC KEWANEE	0	0	0	5,691,530	0.000000
88.01	08801	RURAL HEALTH CLINIC II GALVA	0	0	0	1,406,907	0.000000
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	0	0	0	1,882,958	0.000000
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000
91.00	09100	EMERGENCY	0	0	0	10,258,437	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	441,631	0.000000
200.00		Total (lines 50 through 199)	0	0	0	79,874,008	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	64,906	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	18,696	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	26,568	0	0	0	54.00
54.01	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	10,003	0	0	0	56.00
56.01	03630	ULTRA SOUND	0.000000	5,011	0	0	0	56.01
57.00	05700	CT SCAN	0.000000	44,533	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	57,310	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	356,404	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	23,369	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	115,423	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	97,541	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	53,535	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	7,653	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.000000	79,558	0	0	0	69.01
69.02	03650	VASCULAR LAB	0.000000	9,678	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,810	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	448,512	0	0	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC KEWANEE	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	0.000000	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
91.00	09100	EMERGENCY	0.000000	1,389	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	6,120	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,430,019	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/28/2020 3:09 pm

			Title XVIII		Hospital		Cost	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.319124	0	3,380,876	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.061120	0	498,020	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.516903	0	1,019,388	0	0	54.00
54.01	03440	MAMMOGRAPHY	0.262074	0	152,913	0	0	54.01
56.00	05600	RADIOISOTOPE	0.266696	0	321,827	0	0	56.00
56.01	03630	ULTRA SOUND	0.261926	0	286,733	0	0	56.01
57.00	05700	CT SCAN	0.077649	0	3,193,167	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.112999	0	1,111,284	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.133887	0	5,273,385	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.273608	0	138,477	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.250117	0	478,726	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.405432	0	771,193	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.494851	0	58,750	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.982145	0	20,303	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.211301	0	1,096,528	0	0	69.01
69.02	03650	VASCULAR LAB	0.290076	0	345,290	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.127748	0	223,671	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294444	0	1,806,682	20,646	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC KEWANEE	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	0.000000				0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
91.00	09100	EMERGENCY	0.335202	0	2,450,043	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.626978	0	193,350	0	0	92.00
200.00		Subtotal (see instructions)		0	22,820,606	20,646	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	22,820,606	20,646	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-1325		Period: From 10/01/2018 To 09/30/2019	Worksheet D Part V Date/Time Prepared: 2/28/2020 3:09 pm
			Title XVIII		Hospital	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,078,919	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	30,439	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	526,925	0		54.00
54.01	03440	MAMMOGRAPHY	40,075	0		54.01
56.00	05600	RADIOISOTOPE	85,830	0		56.00
56.01	03630	ULTRA SOUND	75,103	0		56.01
57.00	05700	CT SCAN	247,946	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	125,574	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	706,038	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	37,888	0		62.00
65.00	06500	RESPIRATORY THERAPY	119,738	0		65.00
66.00	06600	PHYSICAL THERAPY	312,666	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	29,072	0		67.00
68.00	06800	SPEECH PATHOLOGY	19,940	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	231,697	0		69.01
69.02	03650	VASCULAR LAB	100,160	0		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,574	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	531,967	6,079		73.00
73.01	03480	ONCOLOGY	0	0		73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC KEWANEE	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	0	0		88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	821,259	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	507,926	0		92.00
200.00		Subtotal (see instructions)	5,657,736	6,079		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,657,736	6,079		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1325

Period:

Worksheet D

Component CCN:14-Z325

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/28/2020 3:09 pm

			Title XVIII		Swing Beds - SNF		Cost		
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.319124	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	0.061120	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.516903	0	0	0	0	54.00	
54.01	03440	MAMMOGRAPHY	0.262074	0	0	0	0	54.01	
56.00	05600	RADIOISOTOPE	0.266696	0	0	0	0	56.00	
56.01	03630	ULTRA SOUND	0.261926	0	0	0	0	56.01	
57.00	05700	CT SCAN	0.077649	0	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.112999	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000	LABORATORY	0.133887	0	0	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.273608	0	0	0	0	62.00	
65.00	06500	RESPIRATORY THERAPY	0.250117	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.405432	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.494851	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.982145	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00	
69.01	03160	CARDIOPULMONARY	0.211301	0	0	0	0	69.01	
69.02	03650	VASCULAR LAB	0.290076	0	0	0	0	69.02	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.127748	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294444	0	0	0	0	73.00	
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC KEWANEE	0.000000				0	88.00	
88.01	08801	RURAL HEALTH CLINIC II GALVA	0.000000				0	88.01	
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	0.000000				0	88.02	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00	
91.00	09100	EMERGENCY	0.335202	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.626978	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:14-1325

Period:

Worksheet D

Component CCN:14-Z325

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/28/2020 3:09 pm

			Title XVIII		Swing Beds - SNF		Cost		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
54.01	03440	MAMMOGRAPHY	0	0					54.01
56.00	05600	RADIOISOTOPE	0	0					56.00
56.01	03630	ULTRA SOUND	0	0					56.01
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0					58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0					59.00
60.00	06000	LABORATORY	0	0					60.00
60.01	06001	BLOOD LABORATORY	0	0					60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0					62.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
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
69.01	03160	CARDIOPULMONARY	0	0					69.01
69.02	03650	VASCULAR LAB	0	0					69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
73.01	03480	ONCOLOGY	0	0					73.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC KEWANEE	0	0					88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	0	0					88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	0	0					88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0					89.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	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 ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part I
Date/Time Prepared:
2/28/2020 3:09 pm

			Title XIX		Hospital	Cost	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	498,944	0	498,944	1,590	313.80	30.00
31.00	INTENSIVE CARE UNIT	49,112		49,112	21	2,338.67	31.00
200.00	Total (lines 30 through 199)	548,056		548,056	1,611		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	31	9,728				30.00
31.00	INTENSIVE CARE UNIT	4	9,355				31.00
200.00	Total (lines 30 through 199)	35	19,083				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part II
Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description		Capital Related Cost (from Wkst. C, 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	348,020	0	0.000000	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	42,385	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	679,311	0	0.000000	0	0	54.00
54.01	03440 MAMMOGRAPHY	6,296	0	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	8,630	0	0.000000	0	0	56.00
56.01	03630 ULTRA SOUND	14,198	0	0.000000	0	0	56.01
57.00	05700 CT SCAN	21,517	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	40,994	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	208,345	0	0.000000	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	4,295	0	0.000000	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	22,207	0	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	81,614	0	0.000000	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	10,250	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	5,091	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	03160 CARDIOPULMONARY	120,721	0	0.000000	0	0	69.01
69.02	03650 VASCULAR LAB	5,038	0	0.000000	0	0	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	839	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	87,461	0	0.000000	0	0	73.00
73.01	03480 ONCOLOGY	0	0	0.000000	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC KEWANEE	274,984	0	0.000000	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II GALVA	10,576	0	0.000000	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III SHEFFIELD	20,819	0	0.000000	0	0	88.02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100 EMERGENCY	203,583	0	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	2,217,174	0		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-1325		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part III Date/Time Prepared: 2/28/2020 3:09 pm		
					Title XIX			Hospital		Cost	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	1,590	0.00		31	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	21	0.00		4	31.00	
200.00		Total (lines 30 through 199)		0	0	1,611			35	200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0							30.00
31.00	03100	INTENSIVE CARE UNIT		0							31.00
200.00		Total (lines 30 through 199)		0							200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description			Title XIX		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03440	MAMMOGRAPHY	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	03630	ULTRA SOUND	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
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
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
69.02	03650	VASCULAR LAB	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC KEWANEE	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	0	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1325		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/28/2020 3:09 pm	
				Title XIX		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)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	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	0	0.000000	54.00
54.01	03440	MAMMOGRAPHY		0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE		0	0	0	0	0.000000	56.00
56.01	03630	ULTRA SOUND		0	0	0	0	0.000000	56.01
57.00	05700	CT SCAN		0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	0	0.000000	60.00
60.01	06001	BLOOD LABORATORY		0	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0.000000	69.00
69.01	03160	CARDIOPULMONARY		0	0	0	0	0.000000	69.01
69.02	03650	VASCULAR LAB		0	0	0	0	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0.000000	73.00
73.01	03480	ONCOLOGY		0	0	0	0	0.000000	73.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC KEWANEE		0	0	0	0	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA		0	0	0	0	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD		0	0	0	0	0.000000	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	0.000000	89.00
91.00	09100	EMERGENCY		0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019

Worksheet D
Part IV
Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description			Title XIX		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	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	0.000000	0	0	0	0	54.00
54.01	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
56.01	03630	ULTRA SOUND	0.000000	0	0	0	0	56.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.000000	0	0	0	0	69.01
69.02	03650	VASCULAR LAB	0.000000	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC KEWANEE	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	0.000000	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1325	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/28/2020 3:09 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,055	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,590	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)			995	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			112	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)			336	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			4	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)			13	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			604	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)			68	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)			205	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			157.19	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			159.97	20.00
21.00	Total general inpatient routine service cost (see instructions)			3,976,482	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)			629	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)			2,080	25.00
26.00	Total swing-bed cost (see instructions)			876,237	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,100,245	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)			3,100,245	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)			1,949.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,177,703	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,177,703	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	162,188	21	7,723.24	12	92,679	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)					374,749	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,645,131	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					132,589	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					399,717	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					532,306	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)					595	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,949.84	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,160,155	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/28/2020 3:09 pm

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	498,944	3,976,482	0.125474	1,160,155	145,569
91.00	Nursing School cost	0	3,976,482	0.000000	1,160,155	0
92.00	Allied health cost	0	3,976,482	0.000000	1,160,155	0
93.00	All other Medical Education	0	3,976,482	0.000000	1,160,155	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1325	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/28/2020 3:09 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		884,746	30.00
31.00	03100	INTENSIVE CARE UNIT		40,176	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.319124	64,906	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.061120	18,696	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.516903	26,568	54.00
54.01	03440	MAMMOGRAPHY	0.262074	0	54.01
56.00	05600	RADIOISOTOPE	0.266696	10,003	56.00
56.01	03630	ULTRA SOUND	0.261926	5,011	56.01
57.00	05700	CT SCAN	0.077649	44,533	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.112999	57,310	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.133887	356,404	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.273608	23,369	62.00
65.00	06500	RESPIRATORY THERAPY	0.250117	115,423	65.00
66.00	06600	PHYSICAL THERAPY	0.405432	97,541	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.494851	53,535	67.00
68.00	06800	SPEECH PATHOLOGY	0.982145	7,653	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
69.01	03160	CARDIOPULMONARY	0.211301	79,558	69.01
69.02	03650	VASCULAR LAB	0.290076	9,678	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.127748	3,810	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294444	448,512	73.00
73.01	03480	ONCOLOGY	0.000000	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC KEWANEE	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	0.000000		88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	09100	EMERGENCY	0.335202	1,389	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.626978	6,120	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,430,019	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)		1,430,019	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1325	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3
			Component CCN: 14-Z325		Date/Time Prepared: 2/28/2020 3:09 pm
			Title XVIII	Swing Beds - SNF	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.319124	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.061120	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.516903	2,059	54.00
54.01	03440	MAMMOGRAPHY	0.262074	0	54.01
56.00	05600	RADIOISOTOPE	0.266696	0	56.00
56.01	03630	ULTRA SOUND	0.261926	0	56.01
57.00	05700	CT SCAN	0.077649	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.112999	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.133887	45,160	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.273608	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.250117	12,961	65.00
66.00	06600	PHYSICAL THERAPY	0.405432	120,118	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.494851	71,723	67.00
68.00	06800	SPEECH PATHOLOGY	0.982145	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
69.01	03160	CARDIOPULMONARY	0.211301	472	69.01
69.02	03650	VASCULAR LAB	0.290076	880	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.127748	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.294444	154,680	73.00
73.01	03480	ONCOLOGY	0.000000	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC KEWANEE	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II GALVA	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III SHEFFIELD	0.000000		88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	09100	EMERGENCY	0.335202	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.626978	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		408,053	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)		408,053	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1325	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/28/2020 3:09 pm
		Title XVIII	Hospital	Cost
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,663,815	1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)		0	2.00
3.00	OPPI payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,663,815	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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		5,720,453	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)		50,996	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,479,820	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,189,637	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,189,637	30.00
31.00	Primary payer payments		423	31.00
32.00	Subtotal (line 30 minus line 31)		2,189,214	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)		722,295	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		469,492	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		643,675	36.00
37.00	Subtotal (see instructions)		2,658,706	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,658,706	40.00
40.01	Sequestration adjustment (see instructions)		53,174	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		2,901,202	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-295,670	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part I
Date/Time Prepared:
2/28/2020 3:09 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		1,684,305		3,165,355	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	09/16/2019	80,424	09/16/2019	117,675	3.50
3.51		04/17/2019	173,558	04/17/2019	146,478	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)		-253,982		-264,153	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)		1,430,323		2,901,202	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		10,262		295,670	6.02
7.00	Total Medicare program liability (see instructions)		1,420,061		2,605,532	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 PROVIDERS FOR SERVICES RENDERED

Provider CCN:14-1325

Period:

Worksheet E-1

Component CCN:14-Z325

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/28/2020 3:09 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		746,324		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	09/16/2019	30,942		0	3.50
3.51		04/17/2019	62,638		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)		-93,580		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)		652,744		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		11,807		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		664,551		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part II
Date/Time Prepared:
2/28/2020 3:09 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN:14-1325

Period:

Worksheet E-2

Component CCN:14-Z325

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 3:09 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)		537,629	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)		141,848	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		273	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)		679,477	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		679,477	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)		679,477	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		1,364	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		678,113	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)		678,113	0	19.00
19.01	Sequestration adjustment (see instructions)		13,562	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		652,744	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		11,807	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1325	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part V Date/Time Prepared: 2/28/2020 3:09 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,645,131	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,645,131	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,661,582	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)		1,661,582	19.00
20.00	Deductibles (exclude professional component)		254,084	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,407,498	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,407,498	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		63,914	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		41,544	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		54,111	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,449,042	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		1,449,042	30.00
30.01	Sequestration adjustment (see instructions)		28,981	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		1,430,323	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		-10,262	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019

Worksheet G

Date/Time Prepared:
2/28/2020 3:09 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	453,850	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	13,933,375	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,663,675	0	0	0	6.00
7.00	Inventory	471,378	0	0	0	7.00
8.00	Prepaid expenses	11,981	0	0	0	8.00
9.00	Other current assets	118,545	0	0	0	9.00
10.00	Due from other funds	289,265	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,614,719	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,712,018	0	0	0	12.00
13.00	Land improvements	1,321,467	0	0	0	13.00
14.00	Accumulated depreciation	-906,735	0	0	0	14.00
15.00	Buildings	19,976,549	0	0	0	15.00
16.00	Accumulated depreciation	-13,110,685	0	0	0	16.00
17.00	Leasehold improvements	25,127	0	0	0	17.00
18.00	Accumulated depreciation	-25,127	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	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	14,994,239	0	0	0	23.00
24.00	Accumulated depreciation	-11,737,545	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	285,496	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,534,804	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	28,731,673	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	934,385	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	29,666,058	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	49,815,581	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,445,349	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,158,107	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	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	236,488	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,839,944	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	29,538	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	29,538	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,869,482	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	46,946,099	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	46,946,099	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	49,815,581	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-1

Date/Time Prepared:
2/28/2020 3:09 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		39,534,534		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		7,229,729				2.00
3.00	Total (sum of line 1 and line 2)		46,764,263		0		3.00
4.00	TRANSFERS	181,836		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)		181,836		0		10.00
11.00	Subtotal (line 3 plus line 10)		46,946,099		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		46,946,099		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	TRANSFERS		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
2/28/2020 3:09 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,958,624		1,958,624	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	492,800		492,800	5.00
6.00	Swing bed - NF	18,700		18,700	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,470,124		2,470,124	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	70,308		70,308	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)	70,308		70,308	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,540,432		2,540,432	17.00
18.00	Ancillary services	3,927,412	56,265,133	60,192,545	18.00
19.00	Outpatient services	262,773	10,382,564	10,645,337	19.00
20.00	RURAL HEALTH CLINIC KEWANEE	0	5,691,530	5,691,530	20.00
20.01	RURAL HEALTH CLINIC II GALVA	0	1,406,907	1,406,907	20.01
20.02	RURAL HEALTH CLINIC III SHEFFIELD	0	1,882,958	1,882,958	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	114,001	5,057,317	5,171,318	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,844,618	80,686,409	87,531,027	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,456,644		29.00
30.00	ADD (SPECIFY)	0			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)		0		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)		33,456,644		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1325

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-3

Date/Time Prepared:
2/28/2020 3:09 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	87,531,027	1.00
2.00	Less contractual allowances and discounts on patients' accounts	49,751,407	2.00
3.00	Net patient revenues (line 1 minus line 2)	37,779,620	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	33,456,644	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,322,976	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	38,160	6.00
7.00	Income from investments	1,512,239	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	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	0	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	124,175	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	4,166	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	OTHER REVENUE	429,979	24.00
24.01	340B REVENUE	1,242,597	24.01
25.00	Total other income (sum of lines 6-24)	3,351,316	25.00
26.00	Total (line 5 plus line 25)	7,674,292	26.00
27.00	GAIN/LOSS ON DISPOSAL OF ASSETS	28,212	27.00
27.01	EQUITY XFER	416,351	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	444,563	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	7,229,729	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1325

Period:

Worksheet M-1

Component CCN: 14-3445

From 10/01/2018

Date/Time Prepared:

To 09/30/2019

2/28/2020 3:09 pm

				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,227,562	108,012	1,335,574	-172,826	1,162,748	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	642,737	0	642,737	0	642,737	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	865,883	0	865,883	0	865,883	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	68,038	0	68,038	0	68,038	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,804,220	108,012	2,912,232	-172,826	2,739,406	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	169,875	169,875	0	169,875	15.00
16.00	Transportation (Health Care Staff)	0	14,614	14,614	0	14,614	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	51,563	51,563	0	51,563	18.00
19.00	Other Health Care Costs	0	696	696	0	696	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	236,748	236,748	0	236,748	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,804,220	344,760	3,148,980	-172,826	2,976,154	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	24,186	24,186	0	24,186	29.00
30.00	Administrative Costs	286,702	1,478,793	1,765,495	-592,892	1,172,603	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	286,702	1,502,979	1,789,681	-592,892	1,196,789	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,090,922	1,847,739	4,938,661	-765,718	4,172,943	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1325

Period:

Worksheet M-1

Component CCN: 14-3445

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 3:09 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	1,162,748		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	642,737		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	865,883		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	68,038		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,739,406		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	169,875		15.00
16.00	Transportation (Health Care Staff)	0	14,614		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	51,563		18.00
19.00	Other Health Care Costs	0	696		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	236,748		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,976,154		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	24,186		29.00
30.00	Administrative Costs	-10,244	1,162,359		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-10,244	1,186,545		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-10,244	4,162,699		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1325

Period:

Worksheet M-1

Component CCN: 14-8595

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 3:09 pm

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	16,145	0	16,145	2	16,147
2.00	Physician Assistant	108,340	0	108,340	16	108,356
3.00	Nurse Practitioner	711	0	711	0	711
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	83,236	0	83,236	12	83,248
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	208,432	0	208,432	30	208,462
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	25,742	25,742	0	25,742
16.00	Transportation (Health Care Staff)	0	1,079	1,079	0	1,079
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	26,821	26,821	0	26,821
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	208,432	26,821	235,253	30	235,283
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	30,619	30,619	-807	29,812
30.00	Administrative Costs	142,495	281,427	423,922	-225,689	198,233
31.00	Total Facility Overhead (sum of lines 29 and 30)	142,495	312,046	454,541	-226,496	228,045
32.00	Total facility costs (sum of lines 22, 28 and 31)	350,927	338,867	689,794	-226,466	463,328

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1325

Period:

Worksheet M-1

Component CCN: 14-8595

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 3:09 pm

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	16,147	1.00
2.00	Physician Assistant	0	108,356	2.00
3.00	Nurse Practitioner	0	711	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	83,248	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	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	208,462	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	25,742	15.00
16.00	Transportation (Health Care Staff)	0	1,079	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	26,821	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	235,283	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	29,812	29.00
30.00	Administrative Costs	-1,761	196,472	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,761	226,284	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,761	461,567	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1325

Period:

Worksheet M-1

Component CCN: 14-8594

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 3:09 pm

		RHC III		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	303,654	35,523	339,177	91,442	430,619
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	45,393	0	45,393	13,670	59,063
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	186,643	0	186,643	56,205	242,848
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	535,690	35,523	571,213	161,317	732,530
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	73,949	73,949	0	73,949
16.00	Transportation (Health Care Staff)	0	2,556	2,556	0	2,556
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	6,730	6,730	0	6,730
19.00	Other Health Care Costs	0	21,512	21,512	0	21,512
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	104,747	104,747	0	104,747
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	535,690	140,270	675,960	161,317	837,277
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	37,128	37,128	-1,165	35,963
30.00	Administrative Costs	75,355	594,385	669,740	-501,405	168,335
31.00	Total Facility Overhead (sum of lines 29 and 30)	75,355	631,513	706,868	-502,570	204,298
32.00	Total facility costs (sum of lines 22, 28 and 31)	611,045	771,783	1,382,828	-341,253	1,041,575

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1325

Period:

Worksheet M-1

Component CCN: 14-8594

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 3:09 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	430,619		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	59,063		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	242,848		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	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	732,530		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	73,949		15.00
16.00	Transportation (Health Care Staff)	0	2,556		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	6,730		18.00
19.00	Other Health Care Costs	0	21,512		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	104,747		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	837,277		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	35,963		29.00
30.00	Administrative Costs	-61,613	106,722		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-61,613	142,685		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-61,613	979,962		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN:14-1325

Period:

Worksheet M-2

Component CCN:14-3445

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 3:09 pm

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	3.11	7,390	4,200	13,062	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	4.01	8,300	2,100	8,421	3.00
4.00	Subtotal (sum of lines 1 through 3)	7.12	15,690		21,483	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	0.96	712		712	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)	8.08	16,402		22,195	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)				2,976,154	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)				2,976,154	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)				1,186,545	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				2,721,806	15.00
16.00	Total overhead (sum of lines 14 and 15)				3,908,351	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				3,908,351	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				3,908,351	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				6,884,505	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1325

Period:

Worksheet M-2

Component CCN: 14-8595

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 3:09 pm

		RHC II		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	0.04	73	4,200	168
2.00	Physician Assistant	0.66	3,954	2,100	1,386
3.00	Nurse Practitioner	0.04	129	2,100	84
4.00	Subtotal (sum of lines 1 through 3)	0.74	4,156		1,638
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.74	4,156		4,156
9.00	Physician Services Under Agreements		0		0
					1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES					
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				235,283
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				235,283
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				226,284
15.00	Parent provider overhead allocated to facility (see instructions)				266,043
16.00	Total overhead (sum of lines 14 and 15)				492,327
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				492,327
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				492,327
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				727,610

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1325

Period:

Worksheet M-2

Component CCN: 14-8594

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/28/2020 3:09 pm

		RHC III		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.97	3,137	4,200	4,074	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.68	2,016	2,100	1,428	3.00
4.00	Subtotal (sum of lines 1 through 3)	1.65	5,153		5,502	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)	1.65	5,153		5,502	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)				837,277	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)				837,277	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)				142,685	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				499,793	15.00
16.00	Total overhead (sum of lines 14 and 15)				642,478	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				642,478	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				642,478	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				1,479,755	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1325 Component CCN: 14-3445	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3 Date/Time Prepared: 2/28/2020 3:09 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)			6,884,505	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			157,602	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			6,726,903	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			22,195	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)			22,195	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			303.08	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		303.08	303.08	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	3,680	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	1,115,334	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	82	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	24,853	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	24,853	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	1,140,187	16.00
16.01	Total program charges (see instructions)(from contractor's records)			876,141	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			4,817	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			6,269	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.)			863,827	16.04
16.05	Total program cost (see instructions)		0	870,096	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			54,134	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			163,438	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			870,096	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			35,797	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			905,893	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)			905,893	26.00
26.01	Sequestration adjustment (see instructions)			18,118	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			1,048,795	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)			-161,020	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:14-1325 Component CCN:14-8595	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3 Date/Time Prepared: 2/28/2020 3:09 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)			727,610	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			12,825	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			714,785	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,156	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)			4,156	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			171.99	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)			171.99	171.99	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	477	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	82,039	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	82,039	16.00
16.01	Total program charges (see instructions)(from contractor's records)				120,140	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.)				61,518	16.04
16.05	Total program cost (see instructions)			0	61,518	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				5,141	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				23,000	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				61,518	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				4,129	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				65,647	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)				65,647	26.00
26.01	Sequestration adjustment (see instructions)				1,313	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				52,984	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)				11,350	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: 14-1325 Component CCN: 14-8594	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3 Date/Time Prepared: 2/28/2020 3:09 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)			1,479,755	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			49,198	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,430,557	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,502	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)			5,502	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			260.01	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)			260.01	260.01	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	494	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	128,445	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	128,445	16.00
16.01	Total program charges (see instructions)(from contractor's records)				111,836	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				256	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				294	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.)				99,047	16.04
16.05	Total program cost (see instructions)			0	99,341	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				4,342	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				21,448	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				99,341	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				9,326	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				108,667	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)				108,667	26.00
26.01	Sequestration adjustment (see instructions)				2,173	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				102,043	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)				4,451	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 PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1325 Component CCN: 14-3445	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/28/2020 3:09 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		2,739,406	2,739,406	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000753	0.001886	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		2,063	5,167	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		47,949	12,953	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		50,012	18,120	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,976,154	2,976,154	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		3,908,351	3,908,351	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.016804	0.006088	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		65,676	23,794	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		115,688	41,914	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		349	874	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		331.48	47.96	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		86	152	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		28,507	7,290	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			157,602	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			35,797	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1325 Component CCN:14-8595	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/28/2020 3:09 pm	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		208,462	208,462	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000882	0.000026	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		184	5	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		3,943	15	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		4,127	20	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		235,283	235,283	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		492,327	492,327	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.017541	0.000085	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		8,636	42	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		12,763	62	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		34	1	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		375.38	62.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		11	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		4,129	0	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			12,825	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			4,129	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1325 Component CCN:14-8594	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/28/2020 3:09 pm	
		Title XVIII	RHC III	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		732,530	732,530	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001600	0.003222	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,172	2,360	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		19,829	4,476	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		21,001	6,836	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		837,277	837,277	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		642,478	642,478	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.025082	0.008165	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		16,115	5,246	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		37,116	12,082	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		150	302	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		247.44	40.01	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		33	29	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		8,166	1,160	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			49,198	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			9,326	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1325 Component CCN: 14-3445	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/28/2020 3:09 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			1,049,285	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			04/17/2019	490	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)			-490	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			1,048,795	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			161,020	6.02
7.00	Total Medicare program liability (see instructions)			887,775	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:14-1325 Component CCN:14-8595	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/28/2020 3:09 pm	
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			52,984	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)			52,984	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			11,350	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			64,334	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:14-1325 Component CCN:14-8594	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/28/2020 3:09 pm	
			RHC III	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			102,043	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)			102,043	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			4,451	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			106,494	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00