

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1309	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 7/28/2020 3:12 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/28/2020	Time: 3:12 pm
	2. ☐ Manually prepared 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 (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ADVOCATE EUREKA HOSPITAL (14-1309) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 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) MICHAEL VOLANTE

Officer or Administrator of Provider(s)

VP REIMBURSEMENT

Title

(Dated when report is electronically signed.)

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	54,374	177,587	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing Bed - SNF	0	34,033	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		147,921		0	10.00
10.01	RURAL HEALTH CLINIC (RHC) II	0		100,930		0	10.01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	88,407	426,438	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: 14-1309		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 7/28/2020 3:12 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 101 SOUTH MAJOR STREET			PO Box:				1.00		
2.00	City: EUREKA			State: IL		Zip Code: 61530		County: WOODFORD 2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		ADVOCATE EUREKA HOSPITAL	141309	37900	1	01/01/2001	N	O	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		EUREKA SWING BED	14Z309	99914		01/01/2001	N	O	N
8.00	Swing Beds - NF									
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		ADVOCATE EUREKA FAMILY CLINIC	148581	99914		11/29/2017	N	O	N
15.01	Hospital-Based Health Clinic - RHC II		ADVOCATE EL PASO FAMILY CLINIC	148582	99914		11/29/2017	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
17.10	Hospital-Based (CORF) I									
18.00	Renal Dialysis									
19.00	Other									
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2019	12/31/2019		20.00	
21.00	Type of Control (see instructions)					1			21.00	
					1.00	2.00	3.00			
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				N	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	N			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				0	N			23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
7/28/2020 3:12 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	0	25.00
					Urban/Rural S 1.00	Date of Geogr 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.					1		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.					1		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: 1.00	Ending: 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 1.00	Y/N 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 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
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.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1309		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 7/28/2020 3:12 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 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	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
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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		
64.00	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. 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	0.000000

Worksheet S-2
Part I
Date/Time Prepared:
7/28/2020 3:12 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
		1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000			65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
				1.00	2.00	3.00			
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 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)								66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
		1.00	2.00	3.00	4.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000			67.00
					1.00	2.00	3.00		
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.					N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						0		71.00
Inpatient Rehabilitation Facility PPS									
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						0		76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1309	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 7/28/2020 3:12 pm	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	N	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.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1309	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 7/28/2020 3:12 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
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.	N		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:	5,367	0	55,944118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H036	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1309		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 7/28/2020 3:12 pm		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name: ADVOCATE HEALTH CARE		Contractor's Name: NGS		Contractor's Number: 06101				141.00	
142.00	Street: 3075 HIGHLAND PARKWAY		PO Box:						142.00	
143.00	City: DOWNERS GROVE		State: IL		Zip Code: 60515				143.00	
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00	
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							N	145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00	
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			Y	Y	N	N			
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			
161.10	CORF				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	County	State	Zip Code	CBSA	FTE/Campus	
				0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00	
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00	
							Beginning	Ending		
							1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									170.00
							1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							Y	393	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1309	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 7/28/2020 3:12 pm
			Y/N 1.00	Date 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 1.00	Date 2.00	V/I 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 1.00	Type 2.00	Date 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	03/26/2020 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 1.00	Legal Oper. 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	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 1.00	Date 2.00	Y/N 3.00 Date 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		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	05/01/2020	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		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		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1309	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 7/28/2020 3:12 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
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	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.		N	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.	MICHAEL	VOLANTE	41.00
42.00	Enter the employer/company name of the cost report preparer.	ADVOCATE HEALTHCARE		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-929-5771	MICHAEL.VOLANTE@ADVOCATEHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1309	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 7/28/2020 3:12 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.	DIRECTOR REIMBURSEMENT		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: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
7/28/2020 3:12 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	12,768.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	12,768.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	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	12,768.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	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
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC (RHC)	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		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: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
7/28/2020 3:12 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)	337	0	532			1.00
2.00	HMO and other (see instructions)	393	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	740	0	1,051			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	145			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,077	0	1,728			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	0			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)	1,077	0	1,728	0.00	85.36	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	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)			10			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC	5,906	0	15,456	0.00	26.73	26.00
26.01	RURAL HEALTH CLINIC (RHC)	2,636	0	6,696	0.00	9.36	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	121.45	27.00
28.00	Observation Bed Days		1	173			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			1			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: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
7/28/2020 3:12 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	99	0	161	1.00
2.00 HMO and other (see instructions)			60	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	99	0	161	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0		0	0	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
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC (RHC)	0.00					26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

Health Financial Systems		ADVOCATE EUREKA HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1309 Component CCN: 14-8581		Period: From 01/01/2019 To 12/31/2019 Worksheet S-8 Date/Time Prepared: 7/28/2020 3:12 pm	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	105 S MAJOR ST		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	EUREKA IL		61530	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
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	08:00		17:00	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			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
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	WOODFORD		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00
		17:00		17:00	11.00

Health Financial Systems		ADVOCATE EUREKA HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1309	Period: From 01/01/2019	Worksheet S-8
			Component CCN: 14-8581	To 12/31/2019	Date/Time Prepared: 7/28/2020 3:12 pm
			RHC I		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	17:00	08:00	12:00
					11.00

Health Financial Systems		ADVOCATE EUREKA HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1309 Component CCN: 14-8582		Period: From 01/01/2019 To 12/31/2019 Worksheet S-8 Date/Time Prepared: 7/28/2020 3:12 pm	
		RHC II		Cost	
				1.00	
Clinic Address and Identification					
1.00	Street	385 S ORANGE STREET		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	EL PASO IL		61738 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	
		from	to	from	to
		1.00	2.00	3.00	4.00
				Tuesday	
				from	
				5.00	
Facility hours of operations (1)					
11.00	CLINIC	07:30		17:00 08:00 11.00	
				1.00 2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0 13.00	
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			14.00	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
				Total Visits	
				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	WOODFORD		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	07:30	17:00	08:00 17:00 11.00

Health Financial Systems		ADVOCATE EUREKA HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1309	Period: From 01/01/2019	Worksheet S-8
			Component CCN: 14-8582	To 12/31/2019	Date/Time Prepared: 7/28/2020 3:12 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	07:30	17:00	08:00	12:00
					11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1309	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 7/28/2020 3:12 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)		0.583283		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		752,793		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		7,285,630		6.00
7.00	Medicaid cost (line 1 times line 6)		4,249,584		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)		3,496,791		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)		3,496,791		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)	39,403	32,634	72,037	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	22,983	32,634	55,617	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)	22,983	32,634	55,617	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)		731,374		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		154,835		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		238,208		27.01
28.00	Non-Medicare bad debt expense (see instructions)		493,166		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		371,028		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		426,645		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,923,436		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019

Worksheet A

Date/Time Prepared:
7/28/2020 3:12 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (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	NEW CAP REL COSTS-BLDG & FIXT		540,852	540,852	-42,099	498,753	1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION		549,932	549,932	-3,296	546,636	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		421,230	421,230	13,573	434,803	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	125,451	1,408,955	1,534,406	-54,331	1,480,075	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	222,328	472,189	694,517	242,622	937,139	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	578,552	3,434,720	4,013,272	-514,557	3,498,715	5.02
7.00	00700	OPERATION OF PLANT	184,762	767,069	951,831	14,634	966,465	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	39,086	39,086	8.00
9.00	00900	HOUSEKEEPING	196,915	65,503	262,418	-3,211	259,207	9.00
10.00	01000	DIETARY	137,897	49,332	187,229	-550	186,679	10.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	161,020	161,020	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	69,329	4,813	74,142	0	74,142	14.00
15.00	01500	PHARMACY	179,003	493,551	672,554	-300,401	372,153	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	235,485	122,214	357,699	-670	357,029	16.00
17.00	01700	SOCIAL SERVICE	136,391	43,855	180,246	0	180,246	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,032,002	191,377	1,223,379	-201,512	1,021,867	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	444,246	143,634	587,880	-99,952	487,928	50.00
53.00	05300	ANESTHESIOLOGY	257,327	22,516	279,843	15,174	295,017	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	627,403	475,774	1,103,177	-48,608	1,054,569	54.00
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	405,259	572,229	977,488	6,925	984,413	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	173,648	173,648	64.00
65.00	06500	RESPIRATORY THERAPY	54,861	70,564	125,425	-5,168	120,257	65.00
66.00	06600	PHYSICAL THERAPY	285,704	26,207	311,911	10,454	322,365	66.00
67.00	06700	OCCUPATIONAL THERAPY	95,212	6,951	102,163	15	102,178	67.00
68.00	06800	SPEECH PATHOLOGY	23,245	3,510	26,755	-277	26,478	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	271,975	271,975	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,413	6,413	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	315,620	315,620	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,420,405	997,276	3,417,681	-16,755	3,400,926	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	796,039	561,477	1,357,516	45,510	1,403,026	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	29,841	134,629	164,470	0	164,470	90.00
91.00	09100	EMERGENCY	705,621	1,413,315	2,118,936	-25,282	2,093,654	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,243,278	12,993,674	22,236,952	0	22,236,952	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0	194.02
194.03	07953	EDUCATION	1,228	614	1,842	0	1,842	194.03
194.04	07954	SCHOOL THERAPY	665	89	754	0	754	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	9,245,171	12,994,377	22,239,548	0	22,239,548	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019

Worksheet A

Date/Time Prepared:
7/28/2020 3:12 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-193,612	305,141	1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION	0	546,636	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	139,196	573,999	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	261,903	1,741,978	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	-101,513	835,626	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	-1,336,196	2,162,519	5.02
7.00	00700	OPERATION OF PLANT	34,936	1,001,401	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	39,085	78,171	8.00
9.00	00900	HOUSEKEEPING	0	259,207	9.00
10.00	01000	DIETARY	-1,533	185,146	10.00
13.00	01300	NURSING ADMINISTRATION	0	161,020	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	74,142	14.00
15.00	01500	PHARMACY	-199,255	172,898	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,586	355,443	16.00
17.00	01700	SOCIAL SERVICE	0	180,246	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-50,000	971,867	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	487,928	50.00
53.00	05300	ANESTHESIOLOGY	0	295,017	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-40,151	1,014,418	54.00
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	21,612	1,006,025	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	173,648	64.00
65.00	06500	RESPIRATORY THERAPY	0	120,257	65.00
66.00	06600	PHYSICAL THERAPY	-85	322,280	66.00
67.00	06700	OCCUPATIONAL THERAPY	-90	102,088	67.00
68.00	06800	SPEECH PATHOLOGY	-81	26,397	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	271,975	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,413	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	315,620	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-23,132	3,377,794	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	-112,044	1,290,982	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-136,343	28,127	90.00
91.00	09100	EMERGENCY	-849,559	1,244,095	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,548,448	19,688,504	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	194.02
194.03	07953	EDUCATION	-500	1,342	194.03
194.04	07954	SCHOOL THERAPY	0	754	194.04
194.05	07955	VACANT SPACE	0	0	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,548,948	19,690,600	200.00

RECLASSIFICATIONS

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet A-6
Date/Time Prepared:
7/28/2020 3:12 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	315,620		1.00
	TOTALS		0	315,620		
	B - RECLASS BLOOD COSTS					
1.00	INTRAVENOUS THERAPY	64.00	0	264		1.00
2.00	OPERATING ROOM	50.00	0	1,851		2.00
3.00	EMERGENCY	91.00	0	529		3.00
	TOTALS		0	2,644		
	C - RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	460,853		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	47		2.00
3.00	OCCUPATIONAL THERAPY	67.00	0	15		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
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
	TOTALS		0	460,915		
	D - RECLASS LAB REAGENTS AND BLOOD					
1.00	LABORATORY	60.00	0	182,465		1.00
	TOTALS		0	182,465		
	E - RECLASS IMPLANT COSTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	6,413		1.00
	TOTALS		0	6,413		
	F - BROMENN HOME OFFICE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	13,573		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	32,196		2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	96,824	148,463		3.00
4.00	OPERATION OF PLANT	7.00	28,593	6,342		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	21,304	17,782		5.00
6.00	PHARMACY	15.00	12,881	2,857		6.00
7.00	LABORATORY	60.00	17,992	3,991		7.00
	TOTALS		177,594	225,204		
	G - RECLASS INCENTIVE COMP					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	23,783	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	9,025	0		2.00
3.00	ANESTHESIOLOGY	53.00	23,270	0		3.00
4.00	PHYSICAL THERAPY	66.00	11,750	0		4.00
5.00	RURAL HEALTH CLINIC	88.00	8,560	0		5.00
6.00	EMERGENCY	91.00	10,139	0		6.00
	TOTALS		86,527	0		
	I - RECLASSIFY NURSING ADMINISTATOR					
1.00	NURSING ADMINISTRATION	13.00	161,020	0		1.00
	TOTALS		161,020	0		
	J - OUTPATIENT IV THERAPY					
1.00	INTRAVENOUS THERAPY	64.00	156,344	17,040		1.00
	TOTALS		156,344	17,040		
	K - EL PASO RHC BUILDING DEPRECIATION					
1.00	RURAL HEALTH CLINIC (RHC)	88.01	0	45,395		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	45,395		
	L - RURAL HEALTH PHARMACY TECH					
1.00	RURAL HEALTH CLINIC	88.00	108	8		1.00
2.00	RURAL HEALTH CLINIC (RHC)	88.01	107	8		2.00
	TOTALS		215	16		
	M - RECLASS PHYSICIAN LEADERSHIP PAY					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	25,431	0		1.00
	TOTALS		25,431	0		
500.00	Grand Total: Increases		607,131	1,255,712		500.00

RECLASSIFICATIONS

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet A-6
Date/Time Prepared:
7/28/2020 3:12 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	315,620	0		1.00
	TOTALS		0	315,620			
	B - RECLASS BLOOD COSTS						
1.00	LABORATORY	60.00	0	2,644	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	2,644			
	C - RECLASS MEDICAL SUPPLIES						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	2,665	0		1.00
2.00	OPERATION OF PLANT	7.00	0	20,301	0		2.00
3.00	HOUSEKEEPING	9.00	0	3,211	0		3.00
4.00	DIETARY	10.00	0	550	0		4.00
5.00	PHARMACY	15.00	0	288	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	670	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	37,153	0		7.00
8.00	OPERATING ROOM	50.00	0	101,803	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	8,096	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	48,608	0		10.00
11.00	LABORATORY	60.00	0	194,879	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	5,168	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	1,296	0		13.00
14.00	SPEECH PATHOLOGY	68.00	0	277	0		14.00
15.00	EMERGENCY	91.00	0	35,950	0		15.00
	TOTALS		0	460,915			
	D - RECLASS LAB REAGENTS AND BLOOD						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	182,465	0		1.00
	TOTALS		0	182,465			
	E - RECLASS IMPLANT COSTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,413	0		1.00
	TOTALS		0	6,413			
	F - BROMENN HOME OFFICE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	177,594	225,204	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	TOTALS		177,594	225,204			
	G - RECLASS INCENTIVE COMP						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	86,527	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		86,527	0			
	I - RECLASSIFY NURSING ADMINISTRATOR						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	161,020	0	0		1.00
	TOTALS		161,020	0			
	J - OUTPATIENT IV THERAPY						
1.00	ADULTS & PEDIATRICS	30.00	156,344	17,040	0		1.00
	TOTALS		156,344	17,040			
	K - EL PASO RHC BUILDING DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	42,099	9		1.00
2.00	NEW 2016 BUILDING & FIXT ADDITION	1.01	0	3,296	9		2.00
	TOTALS		0	45,395			
	L - RURAL HEALTH PHARMACY TECH						
1.00	PHARMACY	15.00	215	16	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		215	16			
	M - RECLASS PHYSICIAN LEADERSHIP PAY						
1.00	RURAL HEALTH CLINIC	88.00	25,431	0	0		1.00
	TOTALS		25,431	0			
500.00	Grand Total: Decreases		607,131	1,255,712			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
7/28/2020 3:12 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	380,000	0	0	0	0	1.00	
2.00	Land Improvements	1,550,399	0	0	0	0	2.00	
3.00	Buildings and Fixtures	21,953,390	162,598	0	162,598	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	7,656,948	425,576	0	425,576	2,469,777	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	31,540,737	588,174	0	588,174	2,469,777	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	31,540,737	588,174	0	588,174	2,469,777	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	380,000	0				1.00	
2.00	Land Improvements	1,550,399	242,102				2.00	
3.00	Buildings and Fixtures	22,115,988	6,024,768				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	5,612,747	2,131,486				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	29,659,134	8,398,356				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	29,659,134	8,398,356				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
7/28/2020 3:12 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	NEW CAP REL COSTS-BLDG & FIXT	540,852	0	0	0	0	1.00
1.01	NEW 2016 BUILDING & FIXT ADDITION	549,932	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	421,230	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,512,014	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	540,852				1.00
1.01	NEW 2016 BUILDING & FIXT ADDITION	0	549,932				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	421,230				2.00
3.00	Total (sum of lines 1-2)	0	1,512,014				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
7/28/2020 3:12 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	NEW CAP REL COSTS-BLDG & FIXT	13,956,140	0	13,956,140	0.470551	0	1.00
1.01	NEW 2016 BUILDING & FIXT ADDITION	10,090,247	0	10,090,247	0.340207	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	5,612,747	0	5,612,747	0.189242	0	2.00
3.00	Total (sum of lines 1-2)	29,659,134	0	29,659,134	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	305,141	0	1.00
1.01	NEW 2016 BUILDING & FIXT ADDITION	0	0	0	546,636	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	573,999	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,425,776	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	305,141	1.00
1.01	NEW 2016 BUILDING & FIXT ADDITION	0	0	0	0	546,636	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	573,999	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,425,776	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8

Date/Time Prepared:
7/28/2020 3:12 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	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW 2016 BUILDING & FIXT ADDITION (chapter 2)			0 NEW 2016 BUILDING & FIXT ADDITION	1.01	0	1.01
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)			0	0.00	0	8.00
9.00	Parking lot (chapter 21)			0	0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-969,501			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	-169,716			0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,463	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others			0	0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00	Sale of drugs to other than patients			0	0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,579	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 - NEW CAP REL COSTS-BLDG & FIXT	A	-203,640	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - NEW 2016 BUILDING & FIXT ADDITION			0 NEW 2016 BUILDING & FIXT ADDITION	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	487	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist			0 NONPHYSICIAN ANESTHETISTS	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)		-5,000	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8

Date/Time Prepared:
7/28/2020 3:12 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		0		0.00	0	32.00
33.00	OTHER OPERATING REVENUE	B	-59,544	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.00
33.01	OTHER OPERATING REVENUE	B	-2,500	EMERGENCY	91.00	0	33.01
33.02	OTHER OPERATING REVENUE	B	-118,142	PHARMACY	15.00	0	33.02
33.03	OTHER OPERATING REVENUE	B	-40,151	RADIOLOGY-DIAGNOSTIC	54.00	0	33.03
33.04	OTHER OPERATING REVENUE	B	-22,588	RURAL HEALTH CLINIC	88.00	0	33.04
33.05	OTHER OPERATING REVENUE	B	-81	SPEECH PATHOLOGY	68.00	0	33.05
33.06	OTHER OPERATING REVENUE	B	-370	LABORATORY	60.00	0	33.06
33.07	ADVERTISING AND CUST RELATIONS	A	-24,428	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.07
33.08	LOBBYING	A	-8,511	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.08
33.09	LOBBYING	A	-85	PHYSICAL THERAPY	66.00	0	33.09
33.10	LOBBYING	A	-90	OCCUPATIONAL THERAPY	67.00	0	33.10
33.11	LOBBYING	A	-356	RURAL HEALTH CLINIC	88.00	0	33.11
33.12	PHO COSTS	A	-63,019	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.12
33.13	INTEREST EXPENSE	A	-49,180	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.13
33.14	MISC NONALLOWABLE	A	-1,062	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.14
33.15	IDPA TAX ASSESSMENT	A	-346,800	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.15
33.16	MISC NONALLOWABLE COSTS	A	-188	RURAL HEALTH CLINIC	88.00	9	33.16
33.17	ADVERTISING COST	A	-260	RURAL HEALTH CLINIC (RHC)	88.01	0	33.17
33.18	MISC PROMOTIONAL	A	-36,124	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.18
33.19	OTHER OPERATING REVENUE	B	-93,771	RURAL HEALTH CLINIC (RHC)	88.01	0	33.19
33.20	EMPLOYEE HEALTH SELF INS COST	A	-149,344	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	LOBBYING COSTS	A	-13	RURAL HEALTH CLINIC (RHC)	88.01	0	33.21
33.22	MISC PROMOTIONAL	A	-70	DIETARY	10.00	0	33.22
33.23	MISC PROMOTIONAL	A	-500	EDUCATION	194.03	0	33.23
33.24	LOBBYING COSTS	A	-7	MEDICAL RECORDS & LIBRARY	16.00	0	33.24
33.25	340B PHARMACY EXPENSE	A	-96,851	PHARMACY	15.00	0	33.25
33.26	CLINIC REVENUE	B	-58,901	CLINIC	90.00	0	33.26
33.27	OTHER OPERATING REVENUE	B	-7,600	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.27
33.28	BROMENN MEDICAL DIRECTORSHIP	A	-18,000	RURAL HEALTH CLINIC (RHC)	88.01	0	33.28
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,548,948				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: 14-1309

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8-1

Date/Time Prepared:
7/28/2020 3:12 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	NEW CAP REL COSTS-BLDG & FIX	BUILDINGS & FIXTURES	10,028	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	EQUIPMENT	138,709	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EH&W	418,847	0	3.00
4.00	5.01	OTHER ADMINISTRATIVE AND GEN	A&G	245,287	0	4.00
4.03	5.02	OTHER ADMINISTRATIVE AND GEN	A&G	1,778,699	2,873,027	4.03
4.04	7.00	OPERATION OF PLANT	PLANT OPERATIONS	34,936	0	4.04
4.05	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	39,085	0	4.05
4.06	15.00	PHARMACY	PHARMACY	15,738	0	4.06
4.07	60.00	LABORATORY	LAB	21,982	0	4.07
4.09	0.00		0	0	0	4.09
4.10	0.00		0	0	0	4.10
4.11	0.00		0	0	0	4.11
4.12	0.00		0	0	0	4.12
4.13	0.00		0	0	0	4.13
4.14	0.00		0	0	0	4.14
4.15	0.00		0	0	0	4.15
5.00	0		0	2,703,311	2,873,027	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	ADVOCATE HEALTH	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:		0.00		0.00	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.

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

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8-1

Date/Time Prepared:
7/28/2020 3:12 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	10,028	9		1.00
2.00	138,709	9		2.00
3.00	418,847	9		3.00
4.00	245,287	0		4.00
4.03	-1,094,328	0		4.03
4.04	34,936	0		4.04
4.05	39,085	0		4.05
4.06	15,738	0		4.06
4.07	21,982	0		4.07
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
5.00	-169,716			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	HEALTHCARE		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: 14-1309

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8-2

Date/Time Prepared:
7/28/2020 3:12 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	45,000	45,000	0	0	0	1.00
2.00	91.00	EMERGENCY	1,294,796	847,059	447,737	0	0	2.00
3.00	90.00	CLINIC	77,442	77,442	0	0	0	3.00
4.00	0.00		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			1,417,238	969,501	447,737		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	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	0.00		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	45,000		1.00
2.00	91.00	EMERGENCY	0	0	0	847,059		2.00
3.00	90.00	CLINIC	0	0	0	77,442		3.00
4.00	0.00		0	0	0	0		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	969,501		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
7/28/2020 3:12 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW 2016 BUILDING & FIXT ADDITION	MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	305,141	305,141			1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION	546,636	0	546,636		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	573,999		573,999		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,741,978	0	0	1,741,978	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	835,626	6,272	0	60,389	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	2,162,519	39,281	11,594	54,712	5.02
7.00	00700	OPERATION OF PLANT	1,001,401	19,067	91,633	40,370	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	78,171	2,899	0	4,031	8.00
9.00	00900	HOUSEKEEPING	259,207	2,631	2,140	37,260	9.00
10.00	01000	DIETARY	185,146	17,730	0	26,092	10.00
13.00	01300	NURSING ADMINISTRATION	161,020	2,459	0	30,468	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	74,142	0	0	13,118	14.00
15.00	01500	PHARMACY	172,898	0	0	36,267	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	355,443	14,158	0	44,558	16.00
17.00	01700	SOCIAL SERVICE	180,246	1,933	0	25,807	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	971,867	31,241	214,557	167,397	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	487,928	21,586	216,265	84,059	50.00
53.00	05300	ANESTHESIOLOGY	295,017	0	0	53,094	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,014,418	30,033	6,421	118,715	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	1,006,025	9,784	0	80,086	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	173,648	0	0	29,583	64.00
65.00	06500	RESPIRATORY THERAPY	120,257	0	0	10,381	65.00
66.00	06600	PHYSICAL THERAPY	322,280	11,535	0	56,283	66.00
67.00	06700	OCCUPATIONAL THERAPY	102,088	11,526	0	18,016	67.00
68.00	06800	SPEECH PATHOLOGY	26,397	11,863	0	4,398	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	271,975	2,666	4,026	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,413	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	315,620	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,377,794	0	0	454,812	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	1,290,982	0	0	150,644	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	28,127	0	0	5,646	90.00
91.00	09100	EMERGENCY	1,244,095	40,955	0	135,434	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,688,504	277,619	546,636	1,741,620	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	22,932	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	194.02
194.03	07953	EDUCATION	1,342	0	0	232	194.03
194.04	07954	SCHOOL THERAPY	754	0	0	126	194.04
194.05	07955	VACANT SPACE	0	4,590	0	0	194.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,690,600	305,141	546,636	1,741,978	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
7/28/2020 3:12 pm

Cost Center Description			Subtotal	OTHER ADMINISTRATIVE AND GENERAL	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	
			4A	5.01	5A.01	5.02	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	902,287	902,287				5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	2,281,566	152,668	2,434,234	2,434,234		5.02
7.00	00700	OPERATION OF PLANT	1,196,523	80,065	1,276,588	180,079	1,456,667	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	85,101	5,695	90,796	12,808	10,738	8.00
9.00	00900	HOUSEKEEPING	305,188	20,422	325,610	45,932	22,019	9.00
10.00	01000	DIETARY	230,188	15,403	245,591	34,644	65,675	10.00
13.00	01300	NURSING ADMINISTRATION	193,947	12,978	206,925	29,189	9,108	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	87,260	5,839	93,099	13,133	0	14.00
15.00	01500	PHARMACY	231,155	15,468	246,623	34,789	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	414,159	27,713	441,872	62,332	52,444	16.00
17.00	01700	SOCIAL SERVICE	207,986	13,917	221,903	31,302	7,159	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,435,830	96,079	1,531,909	216,096	384,842	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	979,070	65,514	1,044,584	147,352	351,192	50.00
53.00	05300	ANESTHESIOLOGY	348,111	23,294	371,405	52,392	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,386,892	92,804	1,479,696	208,730	119,301	54.00
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	1,108,450	74,172	1,182,622	166,824	36,241	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	203,231	13,599	216,830	30,587	0	64.00
65.00	06500	RESPIRATORY THERAPY	134,434	8,996	143,430	20,233	0	65.00
66.00	06600	PHYSICAL THERAPY	393,433	26,327	419,760	59,213	42,728	66.00
67.00	06700	OCCUPATIONAL THERAPY	131,630	8,808	140,438	19,811	42,697	67.00
68.00	06800	SPEECH PATHOLOGY	43,318	2,899	46,217	6,520	43,943	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	278,667	18,647	297,314	41,940	14,925	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,413	429	6,842	965	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	315,620	21,120	336,740	47,502	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,832,606	0	3,832,606	540,637	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	1,441,626	0	1,441,626	203,360	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	33,773	2,260	36,033	5,083	0	90.00
91.00	09100	EMERGENCY	1,452,160	97,171	1,549,331	218,553	151,707	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,660,624	902,287	19,660,624	2,430,006	1,354,719	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,932	0	22,932	3,235	84,946	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0	194.02
194.03	07953	EDUCATION	1,574	0	1,574	222	0	194.03
194.04	07954	SCHOOL THERAPY	880	0	880	124	0	194.04
194.05	07955	VACANT SPACE	4,590	0	4,590	647	17,002	194.05
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,690,600	902,287	19,690,600	2,434,234	1,456,667	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
7/28/2020 3:12 pm

Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			8.00	9.00	10.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	114,342					8.00
9.00	00900	HOUSEKEEPING	22,182	415,743				9.00
10.00	01000	DIETARY	0	23,627	369,537			10.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	245,222		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	106,232	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,602	0	0	324	16.00
17.00	01700	SOCIAL SERVICE	0	4,697	0	11,521	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	32,640	63,384	369,537	78,634	573	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,558	44,596	0	46,529	673	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	7,658	158	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,953	61,107	0	8,418	442	54.00
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	14,375	0	0	273	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	16,320	0	16,244	97	64.00
65.00	06500	RESPIRATORY THERAPY	432	3,321	0	6,226	1,080	65.00
66.00	06600	PHYSICAL THERAPY	4,291	20,448	0	3,298	670	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,598	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	759	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,653	0	0	99,400	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,403	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	71,544	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	3,377	0	90.00
91.00	09100	EMERGENCY	25,286	77,712	0	63,303	1,132	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,342	415,743	369,537	245,208	106,225	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0	194.02
194.03	07953	EDUCATION	0	0	0	14	7	194.03
194.04	07954	SCHOOL THERAPY	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	114,342	415,743	369,537	245,222	106,232	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1309

Period:
From 01/01/2019
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
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
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	281,412					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	561,574				16.00
17.00	01700	SOCIAL SERVICE	0	0	276,582			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,556	561,574	276,582	0	3,522,327	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,122	0	0	0	1,657,606	50.00
53.00	05300	ANESTHESIOLOGY	892	0	0	0	432,505	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,416	0	0	0	1,902,063	54.00
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	18	0	0	0	1,400,353	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	1,354	0	0	0	281,432	64.00
65.00	06500	RESPIRATORY THERAPY	136	0	0	0	174,858	65.00
66.00	06600	PHYSICAL THERAPY	155	0	0	0	550,563	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	208,544	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	97,439	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	457,232	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,210	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	236,092	0	0	0	620,334	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	4,373,243	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	0	0	1,716,530	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	44,493	90.00
91.00	09100	EMERGENCY	18,671	0	0	0	2,105,695	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	281,412	561,574	276,582	0	19,554,427	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	111,113	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0	194.02
194.03	07953	EDUCATION	0	0	0	0	1,817	194.03
194.04	07954	SCHOOL THERAPY	0	0	0	0	1,004	194.04
194.05	07955	VACANT SPACE	0	0	0	0	22,239	194.05
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	281,412	561,574	276,582	0	19,690,600	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet B
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL			5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL			5.02
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
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	3,522,327	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,657,606	50.00
53.00	05300	ANESTHESIOLOGY	0	432,505	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,902,063	54.00
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	1,400,353	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	281,432	64.00
65.00	06500	RESPIRATORY THERAPY	0	174,858	65.00
66.00	06600	PHYSICAL THERAPY	0	550,563	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	208,544	67.00
68.00	06800	SPEECH PATHOLOGY	0	97,439	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	457,232	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,210	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	620,334	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	4,373,243	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	1,716,530	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	44,493	90.00
91.00	09100	EMERGENCY	0	2,105,695	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	19,554,427	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	111,113	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	194.02
194.03	07953	EDUCATION	0	1,817	194.03
194.04	07954	SCHOOL THERAPY	0	1,004	194.04
194.05	07955	VACANT SPACE	0	22,239	194.05
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	19,690,600	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet B
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			NEW BLDG & FIXT	NEW 2016 BUILDING & FIXT ADDITION	MVBLE EQUIP		
		0	1.00	1.01	2.00	2A	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	0	6,272	0	6,272	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	0	39,281	11,594	64,335	5.02
7.00	00700	OPERATION OF PLANT	700	19,067	91,633	155,452	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,899	0	2,899	8.00
9.00	00900	HOUSEKEEPING	0	2,631	2,140	8,721	9.00
10.00	01000	DIETARY	0	17,730	0	18,950	10.00
13.00	01300	NURSING ADMINISTRATION	0	2,459	0	2,459	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	21,990	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,266	14,158	0	23,424	16.00
17.00	01700	SOCIAL SERVICE	0	1,933	0	1,933	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,223	31,241	214,557	300,789	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	21,586	216,265	407,083	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	108,333	30,033	6,421	362,092	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	9,784	0	22,339	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,796	65.00
66.00	06600	PHYSICAL THERAPY	0	11,535	0	14,870	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,526	0	11,526	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,863	0	12,523	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,666	4,026	6,692	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
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	216,714	0	0	216,714	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	8,854	0	0	8,854	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	40,955	0	72,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	31,676	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	348,090	277,619	546,636	1,746,344	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	22,932	0	22,932	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	194.02
194.03	07953	EDUCATION	0	0	0	0	194.03
194.04	07954	SCHOOL THERAPY	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	4,590	0	4,590	194.05
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)	348,090	305,141	546,636	1,773,866	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	OTHER ADMINISTRATIVE AND GENERAL	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	5.01	5.02	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	0	6,272				5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	0	1,061	65,396			5.02
7.00	00700	OPERATION OF PLANT	0	556	4,838	160,846		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	40	344	1,186	4,469	8.00
9.00	00900	HOUSEKEEPING	0	142	1,234	2,431	867	9.00
10.00	01000	DIETARY	0	107	931	7,252	0	10.00
13.00	01300	NURSING ADMINISTRATION	0	90	784	1,006	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	41	353	0	0	14.00
15.00	01500	PHARMACY	0	107	935	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	193	1,675	5,791	0	16.00
17.00	01700	SOCIAL SERVICE	0	97	841	790	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	668	5,806	42,494	1,275	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	455	3,959	38,779	452	50.00
53.00	05300	ANESTHESIOLOGY	0	162	1,408	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	645	5,608	13,173	702	54.00
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	515	4,482	4,002	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	95	822	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	63	544	0	17	65.00
66.00	06600	PHYSICAL THERAPY	0	183	1,591	4,718	168	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	61	532	4,715	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	20	175	4,852	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	130	1,127	1,648	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3	26	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	147	1,276	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	14,519	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	5,464	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	16	137	0	0	90.00
91.00	09100	EMERGENCY	0	675	5,872	16,752	988	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,272	65,283	149,589	4,469	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	87	9,380	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0	194.02
194.03	07953	EDUCATION	0	0	6	0	0	194.03
194.04	07954	SCHOOL THERAPY	0	0	3	0	0	194.04
194.05	07955	VACANT SPACE	0	0	17	1,877	0	194.05
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	6,272	65,396	160,846	4,469	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
7/28/2020 3:12 pm

Cost Center Description		HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 NEW 2016 BUILDING & FIXT ADDITION						1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590 OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING	13,395					9.00
10.00	01000 DIETARY	761	28,001				10.00
13.00	01300 NURSING ADMINISTRATION	0	0	4,339			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	394		14.00
15.00	01500 PHARMACY	0	0	0	0	23,032	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	148	0	0	1	0	16.00
17.00	01700 SOCIAL SERVICE	151	0	204	0	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,042	28,001	1,393	2	537	30.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,437	0	823	2	910	50.00
53.00	05300 ANESTHESIOLOGY	0	0	135	1	73	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,969	0	149	2	525	54.00
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	463	0	0	1	1	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	526	0	287	0	111	64.00
65.00	06500 RESPIRATORY THERAPY	107	0	110	4	11	65.00
66.00	06600 PHYSICAL THERAPY	659	0	58	2	13	66.00
67.00	06700 OCCUPATIONAL THERAPY	180	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	24	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	118	0	0	370	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	19,323	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC (RHC)	2,305	0	0	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	60	0	0	90.00
91.00	09100 EMERGENCY	2,505	0	1,120	4	1,528	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	13,395	28,001	4,339	394	23,032	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100 RESEARCH	0	0	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950 TOWN & COUNTRY RHC BLD	0	0	0	0	0	194.00
194.01	07951 WOODFORD PUBLIC HEALTH	0	0	0	0	0	194.01
194.02	07952 RENTAL PROPERTIES	0	0	0	0	0	194.02
194.03	07953 EDUCATION	0	0	0	0	0	194.03
194.04	07954 SCHOOL THERAPY	0	0	0	0	0	194.04
194.05	07955 VACANT SPACE	0	0	0	0	0	194.05
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	13,395	28,001	4,339	394	23,032	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
7/28/2020 3:12 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
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
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	31,232					16.00
17.00	01700	SOCIAL SERVICE	0	4,016				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,232	4,016		418,255	0	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0		0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0		0	0	41.00
42.00	04200	SUBPROVIDER	0	0		0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0		453,900	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0		1,779	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		384,865	0	54.00
57.00	05700	CT SCAN	0	0		0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		0	0	59.00
60.00	06000	LABORATORY	0	0		31,803	0	60.00
60.01	06001	BLOOD LABORATORY	0	0		0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0		1,841	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0		4,652	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0		22,262	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		17,014	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0		17,594	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		10,085	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		34	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		20,746	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0		231,233	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0		16,623	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89.00
90.00	09000	CLINIC	0	0		213	0	90.00
91.00	09100	EMERGENCY	0	0		102,075	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0		0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0		0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0		0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0		0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,232	4,016	0	1,734,974	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190.00
191.00	19100	RESEARCH	0	0		0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		32,399	0	192.00
193.00	19300	NONPAID WORKERS	0	0		0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0		0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0		0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0		0	0	194.02
194.03	07953	EDUCATION	0	0		6	0	194.03
194.04	07954	SCHOOL THERAPY	0	0		3	0	194.04
194.05	07955	VACANT SPACE	0	0		6,484	0	194.05
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	31,232	4,016	0	1,773,866	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
7/28/2020 3:12 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00500	OTHER ADMINISTRATIVE AND GENERAL	5.01
5.02	00500	OTHER ADMINISTRATIVE AND GENERAL	5.02
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
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	33.00
41.00	04100	SUBPROVIDER - IRF	41.00
42.00	04200	SUBPROVIDER	42.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION	109.00
110.00	11000	INTESTINAL ACQUISITION	110.00
111.00	11100	ISLET ACQUISITION	111.00
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	194.01
194.02	07952	RENTAL PROPERTIES	194.02
194.03	07953	EDUCATION	194.03
194.04	07954	SCHOOL THERAPY	194.04
194.05	07955	VACANT SPACE	194.05
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
7/28/2020 3:12 pm

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			NEW BLDG & FIXT (SQUARE FEET)	NEW 2016 BUILDING & FIXT ADDITION (NEW BUILDING SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
			1.00	1.01	2.00			
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	35,368					1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION	0	21,452				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			421,715			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	9,206,247		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	727	0	0	319,152	-902,287	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	4,553	455	9,889	289,152	0	5.02
7.00	00700	OPERATION OF PLANT	2,210	3,596	32,365	213,355	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	336	0	0	21,304	0	8.00
9.00	00900	HOUSEKEEPING	305	84	2,902	196,915	0	9.00
10.00	01000	DIETARY	2,055	0	896	137,897	0	10.00
13.00	01300	NURSING ADMINISTRATION	285	0	0	161,020	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	69,329	0	14.00
15.00	01500	PHARMACY	0	0	16,156	191,669	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,641	0	0	235,485	0	16.00
17.00	01700	SOCIAL SERVICE	224	0	0	136,391	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,621	8,420	37,299	884,683	0	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,502	8,487	124,334	444,246	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	280,597	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,481	252	159,654	627,403	0	54.00
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	1,134	0	9,224	423,251	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	156,344	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	2,789	54,861	0	65.00
66.00	06600	PHYSICAL THERAPY	1,337	0	2,450	297,454	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,336	0	0	95,212	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,375	0	485	23,245	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	309	158	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
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,403,642	-3,832,606	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	0	796,146	-1,441,626	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	29,841	0	90.00
91.00	09100	EMERGENCY	4,747	0	23,272	715,760	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,178	21,452	421,715	9,204,354	-6,176,519	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,658	0	0	0	-22,932	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0	194.02
194.03	07953	EDUCATION	0	0	0	1,228	-1,574	194.03
194.04	07954	SCHOOL THERAPY	0	0	0	665	-880	194.04
194.05	07955	VACANT SPACE	532	0	0	0	-4,590	194.05
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)	305,141	546,636	573,999	1,741,978		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
7/28/2020 3:12 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		NEW BLDG & FIXT (SQUARE FEET)	NEW 2016 BUILDING & FIXT ADDITION (NEW BUILDING SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
		1.00	1.01	2.00			
203.00	Unit cost multiplier (Wkst. B, Part I)	8.627601	25.481820	1.361106	0.189217		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.000000		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: 14-1309

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
7/28/2020 3:12 pm

Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5.01	5A.02	5.02	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	13,484,105					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	2,281,566	-2,434,234	17,256,366			5.02
7.00	00700	OPERATION OF PLANT	1,196,523	0	1,276,588	45,580		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	85,101	0	90,796	336	50,315	8.00
9.00	00900	HOUSEKEEPING	305,188	0	325,610	689	9,761	9.00
10.00	01000	DIETARY	230,188	0	245,591	2,055	0	10.00
13.00	01300	NURSING ADMINISTRATION	193,947	0	206,925	285	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	87,260	0	93,099	0	0	14.00
15.00	01500	PHARMACY	231,155	0	246,623	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	414,159	0	441,872	1,641	0	16.00
17.00	01700	SOCIAL SERVICE	207,986	0	221,903	224	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,435,830	0	1,531,909	12,042	14,363	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	979,070	0	1,044,584	10,989	5,086	50.00
53.00	05300	ANESTHESIOLOGY	348,111	0	371,405	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,386,892	0	1,479,696	3,733	7,900	54.00
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	1,108,450	0	1,182,622	1,134	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	203,231	0	216,830	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	134,434	0	143,430	0	190	65.00
66.00	06600	PHYSICAL THERAPY	393,433	0	419,760	1,337	1,888	66.00
67.00	06700	OCCUPATIONAL THERAPY	131,630	0	140,438	1,336	0	67.00
68.00	06800	SPEECH PATHOLOGY	43,318	0	46,217	1,375	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	278,667	0	297,314	467	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,413	0	6,842	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	315,620	0	336,740	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	3,832,606	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	1,441,626	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	33,773	0	36,033	0	0	90.00
91.00	09100	EMERGENCY	1,452,160	0	1,549,331	4,747	11,127	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,484,105	-2,434,234	17,226,390	42,390	50,315	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	22,932	2,658	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0	194.02
194.03	07953	EDUCATION	0	0	1,574	0	0	194.03
194.04	07954	SCHOOL THERAPY	0	0	880	0	0	194.04
194.05	07955	VACANT SPACE	0	0	4,590	532	0	194.05
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	902,287		2,434,234	1,456,667	114,342	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.066915		0.141063	31.958469	2.272523	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
7/28/2020 3:12 pm

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5.01	5A.02	5.02	7.00	8.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	6,272		65,396	160,846	4,469	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000465		0.003790	3.528872	0.088820	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: 14-1309

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
7/28/2020 3:12 pm

Cost Center Description			HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (HOURS OF SERVICE)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIO)	PHARMACY (COSTED REQUISITIO)	
			9.00	10.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	8,763					9.00
10.00	01000	DIETARY	498	200				10.00
13.00	01300	NURSING ADMINISTRATION	0	0	71,603			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	485,669		14.00
15.00	01500	PHARMACY	0	0	0	0	223,038	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	97	0	0	1,479	0	16.00
17.00	01700	SOCIAL SERVICE	99	0	3,364	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,336	200	22,961	2,619	5,196	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	940	0	13,586	3,078	8,815	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,236	724	707	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,288	0	2,458	2,021	5,085	54.00
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	303	0	0	1,247	14	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	344	0	4,743	445	1,073	64.00
65.00	06500	RESPIRATORY THERAPY	70	0	1,818	4,939	108	65.00
66.00	06600	PHYSICAL THERAPY	431	0	963	3,061	123	66.00
67.00	06700	OCCUPATIONAL THERAPY	118	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	16	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	77	0	0	454,440	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,413	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	187,119	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	1,508	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	986	0	0	90.00
91.00	09100	EMERGENCY	1,638	0	18,484	5,173	14,798	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,763	200	71,599	485,639	223,038	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0	194.02
194.03	07953	EDUCATION	0	0	4	30	0	194.03
194.04	07954	SCHOOL THERAPY	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	415,743	369,537	245,222	106,232	281,412	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	47.442999	1,847.685000	3.424745	0.218733	1.261722	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
7/28/2020 3:12 pm

Cost Center Description		HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (HOURS OF SERVICE)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIO)	PHARMACY (COSTED REQUISITIO)	
		9.00	10.00	13.00	14.00	15.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	13,395	28,001	4,339	394	23,032	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.528586	140.005000	0.060598	0.000811	0.103265	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: 14-1309

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
7/28/2020 3:12 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL				5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL				5.02
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
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	200			16.00
17.00	01700	SOCIAL SERVICE	0	100		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	200	100	0	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	200	100	100	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	194.02
194.03	07953	EDUCATION	0	0	0	194.03
194.04	07954	SCHOOL THERAPY	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	194.05
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)	561,574	276,582	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2,807.870000	2,765.820000	0.000000	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
7/28/2020 3:12 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		16.00	17.00	19.00		
204.00	Cost to be allocated (per Wkst. B, Part II)	31,232	4,016	0		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	156.160000	40.160000	0.000000		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
7/28/2020 3:12 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	3,522,327		3,522,327	0	0	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,657,606		1,657,606	0	0	50.00
53.00	05300	ANESTHESIOLOGY	432,505		432,505	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,902,063		1,902,063	0	0	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,400,353		1,400,353	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	281,432		281,432	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	174,858	0	174,858	0	0	65.00
66.00	06600	PHYSICAL THERAPY	550,563	0	550,563	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	208,544	0	208,544	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	97,439	0	97,439	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	457,232		457,232	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,210		9,210	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	620,334		620,334	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,373,243		4,373,243	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	1,716,530		1,716,530	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	44,493		44,493	0	0	90.00
91.00	09100	EMERGENCY	2,105,695		2,105,695	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	344,746		344,746	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	19,899,173	0	19,899,173	0	0	200.00
201.00		Less Observation Beds	344,746		344,746		0	201.00
202.00		Total (see instructions)	19,554,427	0	19,554,427	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
7/28/2020 3:12 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			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,018,261		1,018,261			30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,775	1,901,446	1,903,221	0.870948	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	10,096	394,264	404,360	1.069604	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	613,975	6,932,560	7,546,535	0.252045	0.000000	54.00
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	1,009,881	4,540,566	5,550,447	0.252296	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	240,879	240,879	1.168354	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	52,112	364,409	416,521	0.419806	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	271,240	655,988	927,228	0.593773	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	77,470	182,482	259,952	0.802240	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	18,165	16,305	34,470	2.826777	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	116,271	76,287	192,558	2.374516	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,075	16,715	17,790	0.517707	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,206,366	1,844,977	4,051,343	0.153118	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	4,468,927	4,468,927			88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	1,744,867	1,744,867			88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	43,945	43,945	1.012470	0.000000	90.00
91.00	09100	EMERGENCY	279,816	4,205,835	4,485,651	0.469429	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	32,720	185,106	217,826	1.582667	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0			99.10
	SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,709,223	27,815,558	33,524,781			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,709,223	27,815,558	33,524,781			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
7/28/2020 3:12 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
33.00	03300	BURN INTENSIVE CARE UNIT				33.00
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
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
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
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
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
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)				88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
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: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
7/28/2020 3:12 pm

			Title XIX	Hospital	Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,522,327		3,522,327	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,657,606		1,657,606	50.00
53.00	05300	ANESTHESIOLOGY	432,505		432,505	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,902,063		1,902,063	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	1,400,353		1,400,353	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	281,432		281,432	64.00
65.00	06500	RESPIRATORY THERAPY	174,858	0	174,858	65.00
66.00	06600	PHYSICAL THERAPY	550,563	0	550,563	66.00
67.00	06700	OCCUPATIONAL THERAPY	208,544	0	208,544	67.00
68.00	06800	SPEECH PATHOLOGY	97,439	0	97,439	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	457,232		457,232	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,210		9,210	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	620,334		620,334	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,373,243		4,373,243	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	1,716,530		1,716,530	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	89.00
90.00	09000	CLINIC	44,493		44,493	90.00
91.00	09100	EMERGENCY	2,105,695		2,105,695	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	344,746		344,746	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0	111.00
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	19,899,173	0	19,899,173	200.00
201.00		Less Observation Beds	344,746		344,746	201.00
202.00		Total (see instructions)	19,554,427	0	19,554,427	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
7/28/2020 3:12 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	1,018,261		1,018,261		30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0		33.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,775	1,901,446	1,903,221	0.870948	50.00
53.00	05300	ANESTHESIOLOGY	10,096	394,264	404,360	1.069604	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	613,975	6,932,560	7,546,535	0.252045	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,009,881	4,540,566	5,550,447	0.252296	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	240,879	240,879	1.168354	64.00
65.00	06500	RESPIRATORY THERAPY	52,112	364,409	416,521	0.419806	65.00
66.00	06600	PHYSICAL THERAPY	271,240	655,988	927,228	0.593773	66.00
67.00	06700	OCCUPATIONAL THERAPY	77,470	182,482	259,952	0.802240	67.00
68.00	06800	SPEECH PATHOLOGY	18,165	16,305	34,470	2.826777	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	116,271	76,287	192,558	2.374516	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,075	16,715	17,790	0.517707	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,206,366	1,844,977	4,051,343	0.153118	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	4,468,927	4,468,927	0.978589	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	1,744,867	1,744,867	0.983760	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	43,945	43,945	1.012470	90.00
91.00	09100	EMERGENCY	279,816	4,205,835	4,485,651	0.469429	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	32,720	185,106	217,826	1.582667	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	5,709,223	27,815,558	33,524,781		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	5,709,223	27,815,558	33,524,781		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
7/28/2020 3:12 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
33.00	03300	BURN INTENSIVE CARE UNIT				33.00
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
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
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
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
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
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0.000000			88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
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: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
7/28/2020 3:12 pm

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)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	453,900	1,903,221	0.238490	1,775	423	50.00
53.00	05300 ANESTHESIOLOGY	1,779	404,360	0.004400	3,451	15	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	384,865	7,546,535	0.050999	314,505	16,039	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	31,803	5,550,447	0.005730	350,410	2,008	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	1,841	240,879	0.007643	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	4,652	416,521	0.011169	19,931	223	65.00
66.00	06600 PHYSICAL THERAPY	22,262	927,228	0.024009	24,490	588	66.00
67.00	06700 OCCUPATIONAL THERAPY	17,014	259,952	0.065451	4,815	315	67.00
68.00	06800 SPEECH PATHOLOGY	17,594	34,470	0.510415	3,620	1,848	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10,085	192,558	0.052374	36,257	1,899	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	34	17,790	0.001911	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	20,746	4,051,343	0.005121	424,154	2,172	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	231,233	4,468,927	0.051742	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC (RHC)	16,623	1,744,867	0.009527	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	213	43,945	0.004847	0	0	90.00
91.00	09100 EMERGENCY	102,075	4,485,651	0.022756	39,508	899	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	40,937	217,826	0.187934	0	0	92.00
200.00	Total (lines 50 through 199)	1,357,656	32,506,520		1,222,916	26,429	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
7/28/2020 3:12 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	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
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
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	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: 14-1309		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 7/28/2020 3:12 pm	
			Title XVIII		Hospital		Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	1,903,221	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	404,360	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,546,535	0.000000	54.00
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	5,550,447	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	240,879	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	416,521	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	927,228	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	259,952	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	34,470	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	192,558	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,790	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,051,343	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,468,927	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	0	1,744,867	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	43,945	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	4,485,651	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	217,826	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	32,506,520		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
7/28/2020 3:12 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	1,775	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	3,451	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	314,505	0	0	0	54.00
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	350,410	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	19,931	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	24,490	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	4,815	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	3,620	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	36,257	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	424,154	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0.000000	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	39,508	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)		1,222,916	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
7/28/2020 3:12 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	0.870948	0	877,501	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.069604	0	174,851	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252045	0	2,649,915	0	0	54.00
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	0.252296	0	2,087,386	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	1.168354	0	146,492	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.419806	0	148,930	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.593773	0	341,757	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.802240	0	56,620	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2.826777	0	11,415	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.374516	0	18,134	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.517707	0	3,715	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153118	0	593,941	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0.000000				0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	1.012470	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.469429	0	1,237,950	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.582667		127,426	0	0	92.00
200.00		Subtotal (see instructions)		0	8,476,033	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	8,476,033	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
7/28/2020 3:12 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	764,258	0		50.00
53.00	05300	ANESTHESIOLOGY	187,021	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	667,898	0		54.00
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	526,639	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	171,155	0		64.00
65.00	06500	RESPIRATORY THERAPY	62,522	0		65.00
66.00	06600	PHYSICAL THERAPY	202,926	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	45,423	0		67.00
68.00	06800	SPEECH PATHOLOGY	32,268	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,059	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,923	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	90,943	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	581,130	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	201,673	0		92.00
200.00		Subtotal (see instructions)	3,578,838	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,578,838	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1309

Period:

From 01/01/2019

To 12/31/2019

Worksheet D

Part IV

Date/Time Prepared:
7/28/2020 3:12 pm

Cost Center Description		Title XVIII		Swing Beds - SNF		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	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
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
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	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: 14-1309

Period:

From 01/01/2019

To 12/31/2019

Worksheet D

Part IV

Date/Time Prepared:
7/28/2020 3:12 pm

Cost Center Description			Title XVIII		Swing Beds - SNF		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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	1,903,221	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	404,360	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,546,535	0.000000	54.00
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	5,550,447	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	240,879	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	416,521	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	927,228	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	259,952	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	34,470	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	192,558	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,790	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,051,343	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,468,927	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	0	1,744,867	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	43,945	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	4,485,651	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	217,826	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	32,506,520		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1309

Period:

Worksheet D

Component CCN: 14-Z309

From 01/01/2019
To 12/31/2019

Part IV
Date/Time Prepared:
7/28/2020 3:12 pm

Cost Center Description		Title XVIII		Swing Beds - SNF		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	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	4,484	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	95,131	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	168,816	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	14,878	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	150,770	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	46,025	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	6,620	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	42,877	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,024,620	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0.000000	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,554,221	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1309

Period:

Worksheet D

Component CCN: 14-Z309

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
7/28/2020 3:12 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	0.870948	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.069604	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252045	0	0	0	0	54.00
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	0.252296	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	1.168354	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.419806	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.593773	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.802240	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2.826777	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.374516	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.517707	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153118	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0.000000				0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	1.012470	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.469429	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.582667	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: 14-1309

Period:

Worksheet D

Component CCN: 14-Z309

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
7/28/2020 3:12 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
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
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
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
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
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
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0					88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0					89.00
90.00	09000	CLINIC	0	0					90.00
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 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
7/28/2020 3:12 pm

			Title XIX		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	0.870948	0	21,147	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.069604	0	2,945	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252045	0	148,789	0	0	54.00
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	0.252296	0	75,206	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	1.168354	0	3,952	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.419806	0	1,435	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.593773	0	8,423	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.802240	0	13,310	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2.826777	0	1,370	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.374516	0	2,380	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.517707	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153118	0	32,709	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.978589				0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0.983760				0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	1.012470	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.469429	0	190,395	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.582667		1,000	0	0	92.00
200.00		Subtotal (see instructions)		0	503,061	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	503,061	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
7/28/2020 3:12 pm

			Title XIX		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	18,418	0		50.00
53.00	05300	ANESTHESIOLOGY	3,150	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,502	0		54.00
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	18,974	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	4,617	0		64.00
65.00	06500	RESPIRATORY THERAPY	602	0		65.00
66.00	06600	PHYSICAL THERAPY	5,001	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	10,678	0		67.00
68.00	06800	SPEECH PATHOLOGY	3,873	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,651	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,008	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	89,377	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,583	0		92.00
200.00		Subtotal (see instructions)	204,434	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	204,434	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1309	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 7/28/2020 3:12 pm	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,901	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			705	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)			532	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			1,051	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			145	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			337	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)			740	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			159.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			159.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			3,522,327	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)			23,055	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			2,117,435	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,404,892	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)			1,404,892	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)			1,992.75	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			671,557	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)			671,557	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019

Worksheet D-1

Date/Time Prepared:
7/28/2020 3:12 pm

			Title XVIII		Hospital	Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					379,503	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,051,060	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)					1,474,635	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,474,635	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)					173	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,992.75	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					344,746	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019

Worksheet D-1

Date/Time Prepared:
7/28/2020 3:12 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	418,255	3,522,327	0.118744	344,746	40,937
91.00	Nursing School cost	0	3,522,327	0.000000	344,746	0
92.00	Allied health cost	0	3,522,327	0.000000	344,746	0
93.00	All other Medical Education	0	3,522,327	0.000000	344,746	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1309	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 7/28/2020 3:12 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
		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		460,790	30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.870948	1,775	50.00
53.00	05300	ANESTHESIOLOGY	1.069604	3,451	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252045	314,505	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.252296	350,410	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
64.00	06400	INTRAVENOUS THERAPY	1.168354	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.419806	19,931	65.00
66.00	06600	PHYSICAL THERAPY	0.593773	24,490	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.802240	4,815	67.00
68.00	06800	SPEECH PATHOLOGY	2.826777	3,620	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.374516	36,257	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.517707	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153118	424,154	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0.000000	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	1.012470	0	90.00
91.00	09100	EMERGENCY	0.469429	39,508	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.582667	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,222,916	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)		1,222,916	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1309	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3
			Component CCN: 14-Z309		Date/Time Prepared: 7/28/2020 3:12 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
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.870948	0	50.00
53.00	05300	ANESTHESIOLOGY	1.069604	4,484	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252045	95,131	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.252296	168,816	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
64.00	06400	INTRAVENOUS THERAPY	1.168354	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.419806	14,878	65.00
66.00	06600	PHYSICAL THERAPY	0.593773	150,770	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.802240	46,025	67.00
68.00	06800	SPEECH PATHOLOGY	2.826777	6,620	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.374516	42,877	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.517707	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153118	1,024,620	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0.000000	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	1.012470	0	90.00
91.00	09100	EMERGENCY	0.469429	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.582667	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,554,221	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)		1,554,221	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1309	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 7/28/2020 3:12 pm	
			Title XIX	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		0		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.870948	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.069604	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.252045	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.252296	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	1.168354	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.419806	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.593773	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.802240	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2.826777	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.374516	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.517707	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153118	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.978589	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0.983760	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	1.012470	0	0	90.00
91.00	09100	EMERGENCY	0.469429	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.582667	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1309	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 7/28/2020 3:12 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,578,838	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		3,578,838	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)		3,614,626	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)		36,009	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,266,867	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)		2,311,750	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)		2,311,750	30.00
31.00	Primary payer payments		1,046	31.00
32.00	Subtotal (line 30 minus line 31)		2,310,704	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)		221,345	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		143,874	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		171,786	36.00
37.00	Subtotal (see instructions)		2,454,578	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)		2,454,578	40.00
40.01	Sequestration adjustment (see instructions)		49,092	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		2,227,899	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		177,587	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
7/28/2020 3:12 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		1,026,584		2,229,148	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	07/24/2019	41,760	07/24/2019	115,399	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	12/31/2019	184,149	12/31/2019	116,648	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-142,389		-1,249	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)		884,195		2,227,899	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		54,374		177,587	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		938,569		2,405,486	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: 14-1309

Period:

Worksheet E-1

Component CCN: 14-Z309

From 01/01/2019

Part I

To 12/31/2019

Date/Time Prepared:

7/28/2020 3:12 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		2,110,366		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	07/24/2019	73,342		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	12/31/2019	300,470		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-227,128		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)		1,883,238		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		34,033		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,917,271		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: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part II
Date/Time Prepared:
7/28/2020 3:12 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: 14-1309	Period: From 01/01/2019 To 12/31/2019	Worksheet E-2	
		Component CCN: 14-Z309		Date/Time Prepared: 7/28/2020 3:12 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)		1,489,381	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		486,285	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		740	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)		1,975,666	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,975,666	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)		1,975,666	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		19,267	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,956,399	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)		1,956,399	0	19.00
19.01	Sequestration adjustment (see instructions)		39,128	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		1,883,238	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		34,033	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
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: 14-1309	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 7/28/2020 3:12 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,051,060	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)		1,051,060	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,061,571	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)		1,061,571	19.00
20.00	Deductibles (exclude professional component)		114,576	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		946,995	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		946,995	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		16,504	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		10,728	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		8,897	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		957,723	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)		957,723	30.00
30.01	Sequestration adjustment (see instructions)		19,154	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		884,195	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		54,374	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
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: 14-1309

Period:
From 01/01/2019
To 12/31/2019

Worksheet G

Date/Time Prepared:
7/28/2020 3:12 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	449,712,000	0	0	0	1.00
2.00 Temporary investments	106,529,000	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	1,620,938,000	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	637,826,000	0	0	0	7.00
8.00 Prepaid expenses	0	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	2,815,005,000	0	0	0	11.00
FIXED ASSETS					
12.00 Land	497,363,000	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	7,875,340,000	0	0	0	15.00
16.00 Accumulated depreciation	0	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	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	2,496,988,000	0	0	0	23.00
24.00 Accumulated depreciation	-4,967,768,000	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	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	5,901,923,000	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	9,140,565,000	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	1,075,876,000	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	10,216,441,000	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	18,933,369,000	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	1,863,035,000	0	0	0	37.00
38.00 Salaries, wages, and fees payable	0	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	77,957,000	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	767,958,000	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	2,708,950,000	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	2,729,366,000	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	1,796,389,000	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	4,525,755,000	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	7,234,705,000	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	11,698,664,000	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)	11,698,664,000	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	18,933,369,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019

Worksheet G-1

Date/Time Prepared:
7/28/2020 3:12 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		10,242,997,000		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,269,058				2.00
3.00	Total (sum of line 1 and line 2)		10,240,727,942		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	ADJ TO AHC FUND BALANCE	1,457,936,058		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)		1,457,936,058		0		10.00
11.00	Subtotal (line 3 plus line 10)		11,698,664,000		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)		11,698,664,000		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	Additions (credit adjustments) (specify)		0				4.00
5.00	ADJ TO AHC FUND BALANCE		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: 14-1309

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
7/28/2020 3:12 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	735,621		735,621	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	282,640		282,640	5.00
6.00	Swing bed - NF	0		0	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)	1,018,261		1,018,261	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,018,261		1,018,261	17.00
18.00	Ancillary services	4,714,424	16,485,362	21,199,786	18.00
19.00	Outpatient services	0	5,564,344	5,564,344	19.00
20.00	RURAL HEALTH CLINIC	0	4,468,927	4,468,927	20.00
20.01	RURAL HEALTH CLINIC (RHC)	0	1,744,867	1,744,867	20.01
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
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,732,685	28,263,500	33,996,185	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,239,548		29.00
30.00	ROUNDING	30			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)		30		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)		22,239,578		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1309

Period:
From 01/01/2019
To 12/31/2019

Worksheet G-3

Date/Time Prepared:
7/28/2020 3:12 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	33,996,185	1.00
2.00	Less contractual allowances and discounts on patients' accounts	14,804,886	2.00
3.00	Net patient revenues (line 1 minus line 2)	19,191,299	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,239,578	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,048,279	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	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	1,463	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	0	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	45,495	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER	732,263	24.00
25.00	Total other income (sum of lines 6-24)	779,221	25.00
26.00	Total (line 5 plus line 25)	-2,269,058	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,269,058	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1309

Period:

Worksheet M-1

Component CCN: 14-8581

From 01/01/2019

Date/Time Prepared:

To 12/31/2019

7/28/2020 3:12 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,308,290	0	1,308,290	0	1,308,290
2.00	Physician Assistant	68,519	0	68,519	0	68,519
3.00	Nurse Practitioner	56,034	0	56,034	0	56,034
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	239,432	0	239,432	0	239,432
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	263,152	0	263,152	0	263,152
10.00	Subtotal (sum of lines 1 through 9)	1,935,427	0	1,935,427	0	1,935,427
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	292,271	292,271	0	292,271
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	3,752	3,752	0	3,752
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	19,561	19,561	0	19,561
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	315,584	315,584	0	315,584
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,935,427	315,584	2,251,011	0	2,251,011
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	5,362	82,776	88,138	0	88,138
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	5,362	82,776	88,138	0	88,138
FACILITY OVERHEAD						
29.00	Facility Costs	0	247,710	247,710	0	247,710
30.00	Administrative Costs	479,616	351,207	830,823	0	830,823
31.00	Total Facility Overhead (sum of lines 29 and 30)	479,616	598,917	1,078,533	0	1,078,533
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,420,405	997,277	3,417,682	0	3,417,682

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1309

Period:

Worksheet M-1

Component CCN: 14-8581

From 01/01/2019

To 12/31/2019

Date/Time Prepared:
7/28/2020 3:12 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	-47,991	1,260,299	1.00
2.00	Physician Assistant	0	68,519	2.00
3.00	Nurse Practitioner	0	56,034	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	239,432	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	263,152	9.00
10.00	Subtotal (sum of lines 1 through 9)	-47,991	1,887,436	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	115	292,386	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	3,752	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	19,561	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	115	315,699	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-47,876	2,203,135	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	88,138	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	88,138	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	247,710	29.00
30.00	Administrative Costs	7,988	838,811	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	7,988	1,086,521	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-39,888	3,377,794	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1309

Period:

Worksheet M-1

Component CCN: 14-8582

From 01/01/2019

Date/Time Prepared:

To 12/31/2019

7/28/2020 3:12 pm

		RHC II		Cost		
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	373,647	198,594	572,241	0	572,241 1.00
2.00	Physician Assistant	119,181	0	119,181	0	119,181 2.00
3.00	Nurse Practitioner	556	0	556	0	556 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	52,398	0	52,398	0	52,398 5.00
6.00	Clinical Psychologist	0	0	0	0	0 6.00
7.00	Clinical Social Worker	0	0	0	0	0 7.00
8.00	Laboratory Technician	0	0	0	0	0 8.00
9.00	Other Facility Health Care Staff Costs	73,259	0	73,259	0	73,259 9.00
10.00	Subtotal (sum of lines 1 through 9)	619,041	198,594	817,635	0	817,635 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	60,719	60,719	0	60,719 15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0 16.00
17.00	Depreciation-Medical Equipment	0	19,066	19,066	0	19,066 17.00
18.00	Professional Liability Insurance	0	0	0	0	0 18.00
19.00	Other Health Care Costs	0	7,424	7,424	0	7,424 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	87,209	87,209	0	87,209 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	619,041	285,803	904,844	0	904,844 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	19,339	19,339	0	19,339 26.00
27.00	Nonallowable GME costs	0	0	0	0	0 27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	19,339	19,339	0	19,339 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	111,323	111,323	0	111,323 29.00
30.00	Administrative Costs	176,998	145,013	322,011	0	322,011 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	176,998	256,336	433,334	0	433,334 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	796,039	561,478	1,357,517	0	1,357,517 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1309

Period:

Worksheet M-1

Component CCN: 14-8582

From 01/01/2019
To 12/31/2019Date/Time Prepared:
7/28/2020 3:12 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	-111,330	460,911		1.00
2.00	Physician Assistant	0	119,181		2.00
3.00	Nurse Practitioner	0	556		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	52,398		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	73,259		9.00
10.00	Subtotal (sum of lines 1 through 9)	-111,330	706,305		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	115	60,834		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	19,066		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	7,424		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	115	87,324		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-111,215	793,629		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	19,339		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	19,339		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	45,394	156,717		29.00
30.00	Administrative Costs	-714	321,297		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	44,680	478,014		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-66,535	1,290,982		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1309

Period:

Worksheet M-2

Component CCN: 14-8581

From 01/01/2019
To 12/31/2019Date/Time Prepared:
7/28/2020 3:12 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	3.63	13,216	4,200	15,246	1.00
2.00	Physician Assistant	0.40	1,308	2,100	840	2.00
3.00	Nurse Practitioner	0.48	923	2,100	1,008	3.00
4.00	Subtotal (sum of lines 1 through 3)	4.51	15,447	17,094	17,094	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.51	15,447		17,094	8.00
9.00	Physician Services Under Agreements		9		9	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)				2,203,135	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				88,138	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				2,291,273	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.961533	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				1,086,521	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				995,449	15.00
16.00	Total overhead (sum of lines 14 and 15)				2,081,970	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				2,081,970	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				2,001,883	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				4,205,018	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1309

Period:

Worksheet M-2

Component CCN: 14-8582

From 01/01/2019
To 12/31/2019Date/Time Prepared:
7/28/2020 3:12 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	0.95	3,356	4,200	3,990		1.00
2.00	Physician Assistant	0.85	2,573	2,100	1,785		2.00
3.00	Nurse Practitioner	0.00	13	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.80	5,942		5,775	5,942	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)	1.80	5,942			5,942	8.00
9.00	Physician Services Under Agreements		754			754	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)					793,629	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					19,339	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					812,968	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.976212	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					478,014	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					425,548	15.00
16.00	Total overhead (sum of lines 14 and 15)					903,562	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					903,562	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					882,068	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,675,697	20.00

Health Financial Systems		ADVOCATE EUREKA HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1309	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3	
		Component CCN: 14-8581		Date/Time Prepared: 7/28/2020 3:12 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)			4,205,018	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			211,293	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,993,725	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			17,094	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			9	5.00
6.00	Total adjusted visits (line 4 plus line 5)			17,103	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			233.51	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)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		233.51	233.51	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	5,906	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	1,379,110	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	1,379,110	16.00
16.01	Total program charges (see instructions)(from contractor's records)			1,340,420	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			2,631	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			2,707	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.)			1,056,188	16.04
16.05	Total program cost (see instructions)		0	1,058,895	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			56,168	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			256,850	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			1,058,895	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			90,434	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			1,149,329	22.00
23.00	Allowable bad debts (see instructions)			359	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			233	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)			1,149,562	26.00
26.01	Sequestration adjustment (see instructions)			22,991	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			978,650	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)			147,921	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		ADVOCATE EUREKA HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1309	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3	
		Component CCN: 14-8582		Date/Time Prepared: 7/28/2020 3:12 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)			1,675,697	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			47,522	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,628,175	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,942	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			754	5.00
6.00	Total adjusted visits (line 4 plus line 5)			6,696	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			243.16	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)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		243.16	243.16	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	2,636	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	640,970	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	640,970	16.00
16.01	Total program charges (see instructions)(from contractor's records)			628,294	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.)			500,616	16.04
16.05	Total program cost (see instructions)		0	500,616	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			15,200	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			122,619	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			500,616	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			19,720	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			520,336	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)			520,336	26.00
26.01	Sequestration adjustment (see instructions)			10,407	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			408,999	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)			100,930	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: 14-1309 Component CCN: 14-8581	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 7/28/2020 3:12 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)		1,887,436	1,887,436	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.002062	0.006917	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		3,892	13,055	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		56,376	37,379	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		60,268	50,434	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,203,135	2,203,135	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,001,883	2,001,883	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.027356	0.022892	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		54,764	45,827	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		115,032	96,261	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		366	1,228	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		314.30	78.39	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		174	456	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		54,688	35,746	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)			211,293	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)			90,434	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1309 Component CCN: 14-8582	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 7/28/2020 3:12 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)		706,305	706,305	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000971	0.003904	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		686	2,757	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		11,456	7,608	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		12,142	10,365	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		793,629	793,629	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		882,068	882,068	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.015299	0.013060	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		13,495	11,520	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		25,637	21,885	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		48	193	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		534.10	113.39	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		21	75	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		11,216	8,504	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)			47,522	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)			19,720	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1309 Component CCN: 14-8581	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 7/28/2020 3:12 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		1,210,959	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		07/24/2019	191,860	3.50	
3.51		12/30/2019	40,449	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)		-232,309	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		978,650	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		147,921	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,126,571	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: 14-1309 Component CCN: 14-8582	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 7/28/2020 3:12 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			808,432	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			07/24/2019	278,289	3.50
3.51			12/31/2019	121,144	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)			-399,433	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			408,999	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			100,930	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			509,929	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00