

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 01/01/2020 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 11/25/2020 11:20 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/25/2020	Time: 11:20 am
	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 01/01/2020 and ending 06/30/2020 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	150,991	570,896	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	212,184	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		30,638		0	10.00
10.01	RURAL HEALTH CLINIC (RHC) II	0		42,850		0	10.01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	363,175	644,384	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 01/01/2020 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/25/2020 11:20 am	
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
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
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
15.01	Hospital-Based Health Clinic - RHC II		ADVOCATE EL PASO FAMILY CLINIC	148582	99914		11/29/2017	N	O
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)						01/01/2020	06/30/2020	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 01/01/2020
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
11/25/2020 11:20 am

	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 OPSS 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 01/01/2020 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/25/2020 11:20 am	
			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)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
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	0.00
			0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
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)		0.00	0.00	0.000000	66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
			1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1309	Period: From 01/01/2020 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/25/2020 11:20 am
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		1.00	
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	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	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	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	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	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	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	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	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	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	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	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	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	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	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	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	N	N	N	N	109.00

		1.00	
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110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1309	Period: From 01/01/2020 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/25/2020 11:20 am
		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:	6,073	0	168,356118.01
		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 01/01/2020 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/25/2020 11:20 am		
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			155.00
156.00	Subprovider - IPF			N	N	N	N			156.00
157.00	Subprovider - IRF			N	N	N	N			157.00
158.00	SUBPROVIDER									158.00
159.00	SNF			N	N	N	N			159.00
160.00	HOME HEALTH AGENCY			N	N	N	N			160.00
161.00	CMHC				N	N	N			161.00
161.10	CORF				N	N	N			161.10
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus	
				0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00	166.00
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									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				130	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1309	Period: From 01/01/2020 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/25/2020 11:20 am
			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.	N		06/30/2020 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		N 16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/08/2020	Y 10/08/2020 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		N 18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N 19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1309	Period: From 01/01/2020 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/25/2020 11:20 am
		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.		Y	12/31/2020
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 01/01/2020 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 11/25/2020 11:20 am
		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 01/01/2020
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/25/2020 11:20 am

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	4,550	5,520.00	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	4,550	5,520.00	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	4,550	5,520.00	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 01/01/2020
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/25/2020 11:20 am

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)	178	0	230			1.00
2.00	HMO and other (see instructions)	130	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	245	0	394			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	36			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	423	0	660			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)	423	0	660	0.00	82.42	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)			0			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	1,977	0	6,417	0.00	22.60	26.00
26.01	RURAL HEALTH CLINIC (RHC)	822	0	2,697	0.00	8.52	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	113.54	27.00
28.00	Observation Bed Days		1	68			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/25/2020 11:20 am

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	46	0	69	1.00
2.00 HMO and other (see instructions)			23	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	46	0	69	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 01/01/2020 To 06/30/2020 Worksheet S-8 Date/Time Prepared: 11/25/2020 11:20 am	
		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?	Y		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 01/01/2020	Worksheet S-8
			Component CCN: 14-8581	To 06/30/2020	Date/Time Prepared: 11/25/2020 11:20 am
			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 01/01/2020 To 06/30/2020 Worksheet S-8 Date/Time Prepared: 11/25/2020 11:20 am	
		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	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	07:30		17:00	08:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y			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
		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		17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1309

Period:

Worksheet S-8

Component CCN: 14-8582

From 01/01/2020
To 06/30/2020Date/Time Prepared:
11/25/2020 11:20 am

RHC II

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1309	Period: From 01/01/2020 To 06/30/2020	Worksheet S-10 Date/Time Prepared: 11/25/2020 11:20 am
			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)		0.775788	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		567,596	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		1,345,450	6.00
7.00	Medicaid cost (line 1 times line 6)		1,043,784	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)		476,188	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)		476,188	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)	120,954	22,752	143,706
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	93,835	22,752	116,587
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	93,835	22,752	116,587
				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
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0
26.00	Total bad debt expense for the entire hospital complex (see instructions)			275,332
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			65,123
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			100,190
28.00	Non-Medicare bad debt expense (see instructions)			175,142
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			170,940
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			287,527
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			763,715

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020

Worksheet A

Date/Time Prepared:
11/25/2020 11:20 am

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		0	0	0	0	1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION		0	0	0	0	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	30,943	705,952	736,895	-4,827	732,068	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	115,930	237,244	353,174	130,464	483,638	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	373,049	2,114,160	2,487,209	-374,421	2,112,788	5.02
7.00	00700	OPERATION OF PLANT	43,996	353,037	397,033	2,170	399,203	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	12,846	12,846	8.00
9.00	00900	HOUSEKEEPING	103,609	31,138	134,747	-2,160	132,587	9.00
10.00	01000	DIETARY	72,661	19,691	92,352	-366	91,986	10.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	36,127	3,239	39,366	0	39,366	14.00
15.00	01500	PHARMACY	106,791	159,116	265,907	-123,782	142,125	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	115,560	11,691	127,251	5,837	133,088	16.00
17.00	01700	SOCIAL SERVICE	95,628	23,716	119,344	962	120,306	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	495,689	64,670	560,359	-60,973	499,386	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	177,905	23,202	201,107	55,347	256,454	50.00
53.00	05300	ANESTHESIOLOGY	128,025	12,152	140,177	-1,842	138,335	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	313,752	197,767	511,519	-12,902	498,617	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	215,666	256,529	472,195	8,423	480,618	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	88,635	88,635	64.00
65.00	06500	RESPIRATORY THERAPY	27,165	36,160	63,325	4,461	67,786	65.00
66.00	06600	PHYSICAL THERAPY	178,377	20,566	198,943	17,219	216,162	66.00
67.00	06700	OCCUPATIONAL THERAPY	48,612	4,139	52,751	3,639	56,390	67.00
68.00	06800	SPEECH PATHOLOGY	8,021	571	8,592	0	8,592	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	92,231	92,231	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,680	3,680	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	130,628	130,628	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,065,467	441,779	1,507,246	11,045	1,518,291	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	434,952	159,125	594,077	7,927	602,004	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	6,194	12,836	19,030	0	19,030	90.00
91.00	09100	EMERGENCY	327,609	876,815	1,204,424	5,759	1,210,183	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)	4,521,728	5,765,295	10,287,023	0	10,287,023	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	190	15	205	0	205	194.03
194.04	07954	SCHOOL THERAPY	41	3	44	0	44	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	4,521,959	5,765,313	10,287,272	0	10,287,272	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020

Worksheet A

Date/Time Prepared:
11/25/2020 11:20 am

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	136,844	136,844	1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION	274,966	274,966	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	291,335	291,335	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	156,797	888,865	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	-45,281	438,357	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	-611,408	1,501,380	5.02
7.00	00700	OPERATION OF PLANT	13,339	412,542	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,846	25,692	8.00
9.00	00900	HOUSEKEEPING	0	132,587	9.00
10.00	01000	DIETARY	-668	91,318	10.00
13.00	01300	NURSING ADMINISTRATION	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	39,366	14.00
15.00	01500	PHARMACY	-58,223	83,902	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	133,088	16.00
17.00	01700	SOCIAL SERVICE	0	120,306	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	24,588	523,974	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	9,129	265,583	50.00
53.00	05300	ANESTHESIOLOGY	0	138,335	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-10,768	487,849	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	10,342	490,960	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	88,635	64.00
65.00	06500	RESPIRATORY THERAPY	0	67,786	65.00
66.00	06600	PHYSICAL THERAPY	0	216,162	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	56,390	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,592	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	92,231	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,680	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	130,628	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-8,341	1,509,950	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	-31,353	570,651	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-19,030	0	90.00
91.00	09100	EMERGENCY	-410,015	800,168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	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)	-264,901	10,022,122	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	0	205	194.03
194.04	07954	SCHOOL THERAPY	0	44	194.04
194.05	07955	VACANT SPACE	0	0	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-264,901	10,022,371	200.00

RECLASSIFICATIONS

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
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	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	130,628		1.00
	TOTALS		0	130,628		
	B - RECLASS BLOOD COSTS					
1.00	INTRAVENOUS THERAPY	64.00	0	147		1.00
2.00	OPERATING ROOM	50.00	0	1,032		2.00
3.00	EMERGENCY	91.00	0	295		3.00
	TOTALS		0	1,474		
	C - RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	184,224		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	670		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
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	184,894		
	D - RECLASS LAB REAGENTS AND BLOOD					
1.00	LABORATORY	60.00	0	88,313		1.00
	TOTALS		0	88,313		
	E - RECLASS IMPLANT COSTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,680		1.00
	TOTALS		0	3,680		
	F - BROMENN HOME OFFICE					
1.00	ADULTS & PEDIATRICS	30.00	20,081	4,507		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	12,743		2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	50,043	78,076		3.00
4.00	OPERATION OF PLANT	7.00	9,044	4,294		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	9,994	2,852		5.00
6.00	PHARMACY	15.00	5,778	1,297		6.00
7.00	LABORATORY	60.00	9,012	2,023		7.00
8.00	OPERATING ROOM	50.00	7,456	1,674		8.00
9.00	EMERGENCY	91.00	8,166	1,833		9.00
	TOTALS		119,574	109,299		
	G - RECLASS INCENTIVE COMP					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	17,570	0		1.00
	TOTALS		17,570	0		
	H - COVID SALARIES TO HOME COST CENTER					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	3,657	0		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	2,641	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	5,167	0		3.00
4.00	SOCIAL SERVICE	17.00	962	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	19,630	0		5.00
6.00	OPERATING ROOM	50.00	51,232	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	17,144	0		7.00
8.00	LABORATORY	60.00	5,192	0		8.00
9.00	RESPIRATORY THERAPY	65.00	7,247	0		9.00
10.00	PHYSICAL THERAPY	66.00	23,172	0		10.00
11.00	OCCUPATIONAL THERAPY	67.00	3,647	0		11.00
12.00	RURAL HEALTH CLINIC	88.00	14,582	0		12.00
13.00	RURAL HEALTH CLINIC (RHC)	88.01	7,864	0		13.00
14.00	EMERGENCY	91.00	7,161	0		14.00
	TOTALS		169,298	0		
	J - OUTPATIENT IV THERAPY					
1.00	INTRAVENOUS THERAPY	64.00	80,403	8,085		1.00
	TOTALS		80,403	8,085		
	L - RURAL HEALTH PHARMACY TECH					
1.00	RURAL HEALTH CLINIC	88.00	59	4		1.00
2.00	RURAL HEALTH CLINIC (RHC)	88.01	59	4		2.00
	TOTALS		118	8		

RECLASSIFICATIONS

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
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Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
M - RECLASS PHYSICIAN LEADERSHIP PAY					
1.00 OTHER ADMINISTRATIVE AND GENERAL	5.02	3,600	0		1.00
TOTALS		3,600	0		
500.00 Grand Total: Increases		390,563	526,381		500.00

RECLASSIFICATIONS

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
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	Decreases						11/25/2020 11:29 am
	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	130,628	0		1.00
	TOTALS		0	130,628			
	B - RECLASS BLOOD COSTS						
1.00	LABORATORY	60.00	0	1,474	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	1,474			
	C - RECLASS MEDICAL SUPPLIES						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	1,312	0		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	61	0		2.00
3.00	OPERATION OF PLANT	7.00	0	11,168	0		3.00
4.00	HOUSEKEEPING	9.00	0	2,160	0		4.00
5.00	DIETARY	10.00	0	366	0		5.00
6.00	PHARMACY	15.00	0	103	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	16,703	0		7.00
8.00	OPERATING ROOM	50.00	0	6,047	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	1,842	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	30,046	0		10.00
11.00	LABORATORY	60.00	0	94,643	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	2,786	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	5,953	0		13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	8	0		14.00
15.00	EMERGENCY	91.00	0	11,696	0		15.00
	TOTALS		0	184,894			
	D - RECLASS LAB REAGENTS AND BLOOD						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	88,313	0		1.00
	TOTALS		0	88,313			
	E - RECLASS IMPLANT COSTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,680	0		1.00
	TOTALS		0	3,680			
	F - BROMENN HOME OFFICE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	119,574	109,299	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
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	TOTALS		119,574	109,299			
	G - RECLASS INCENTIVE COMP						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	17,570	0	0		1.00
	TOTALS		17,570	0			
	H - COVID SALARIES TO HOME COST CENTER						
1.00		0.00	0	0	0		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	169,298	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
	TOTALS		169,298	0			
	J - OUTPATIENT IV THERAPY						
1.00	ADULTS & PEDIATRICS	30.00	80,403	8,085	0		1.00
	TOTALS		80,403	8,085			
	L - RURAL HEALTH PHARMACY TECH						
1.00	PHARMACY	15.00	118	8	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		118	8			

RECLASSIFICATIONS

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
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	Decreases				wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
	M - RECLASS PHYSICIAN LEADERSHIP PAY					
1.00	RURAL HEALTH CLINIC	88.00	3,600	0	0	1.00
	TOTALS		3,600	0		
500.00	Grand Total: Decreases		390,563	526,381		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
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		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	22,115,988	0	0	0	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	5,612,747	365,504	0	365,504	39,829	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	29,659,134	365,504	0	365,504	39,829	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	29,659,134	365,504	0	365,504	39,829	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	392,102				2.00	
3.00	Buildings and Fixtures	22,115,988	70,544,768				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	5,938,422	2,521,371				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	29,984,809	73,458,241				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	29,984,809	73,458,241				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
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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	0	0	0	0	0	1.00
1.01	NEW 2016 BUILDING & FIXT ADDITION	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	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	0				1.00
1.01	NEW 2016 BUILDING & FIXT ADDITION	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
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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	13,536,825	0	13,536,825	0.451456	0	1.00
1.01	NEW 2016 BUILDING & FIXT ADDITION	10,509,562	0	10,509,562	0.350496	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	5,938,422	0	5,938,422	0.198048	0	2.00
3.00	Total (sum of lines 1-2)	29,984,809	0	29,984,809	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	136,844	0	1.00
1.01	NEW 2016 BUILDING & FIXT ADDITION	0	0	0	274,966	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	291,335	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	703,145	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	136,844	1.00
1.01	NEW 2016 BUILDING & FIXT ADDITION	0	0	0	0	274,966	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	291,335	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	703,145	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
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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	-417,765			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	-14,206			0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-668	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			0	0.00	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	131,830	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - NEW 2016 BUILDING & FIXT ADDITION	A	274,966	NEW 2016 BUILDING & FIXT ADDITION	1.01	9	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	228,767	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)			0 ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
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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	-25,139	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.00
33.01	OTHER OPERATING REVENUE	B	-2,250	EMERGENCY	91.00	0	33.01
33.02	OTHER OPERATING REVENUE	B	-62,097	PHARMACY	15.00	0	33.02
33.03	OTHER OPERATING REVENUE	B	-10,768	RADIOLOGY-DIAGNOSTIC	54.00	0	33.03
33.04	OTHER OPERATING REVENUE	B	2,000	RURAL HEALTH CLINIC	88.00	0	33.04
33.05	OTHER OPERATING REVENUE	B	-54,880	RURAL HEALTH CLINIC (RHC)	88.01	0	33.05
33.06	OTHER OPERATING REVENUE	B	-693	LABORATORY	60.00	0	33.06
33.07	ADVERTISING AND CUST RELATIONS	A	-8,229	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.07
33.08	LOBBYING	A	-4,763	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.08
33.09	LOBBYING	A	-122	RURAL HEALTH CLINIC (RHC)	88.01	0	33.09
33.10	EUREKA RHC DEPRECIATION	A	3,743	RURAL HEALTH CLINIC	88.00	0	33.10
33.11	EL PASO RHC DEPRECIATION	A	32,712	RURAL HEALTH CLINIC (RHC)	88.01	0	33.11
33.12	PHO COSTS	A	-43,608	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.12
33.13	INTEREST EXPENSE	A	-25,375	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.13
33.14	NURSING HOME LEADERSHIP PAY	A	-14,012	RURAL HEALTH CLINIC	88.00	0	33.14
33.15	IDPA TAX ASSESSMENT	A	-173,400	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.15
33.16	MISC NONALLOWABLE COSTS	A	-22	RURAL HEALTH CLINIC	88.00	9	33.16
33.17	ADVERTISING COST	A	-63	RURAL HEALTH CLINIC (RHC)	88.01	0	33.17
33.18	MISC PROMOTIONAL	A	-50	RURAL HEALTH CLINIC	88.00	0	33.18
33.19	OTHER OPERATING REVENUE		0		0.00	0	33.19
33.20	EMPLOYEE HEALTH SELF INS COST	A	-49,872	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	PHYSICIAN RECOGNITION	A	-306	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.21
33.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.22
33.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.23
33.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.24
33.25	340B PHARMACY EXPENSE	A	-3,201	PHARMACY	15.00	0	33.25
33.26	PAIN CLINIC COSTS	A	-19,030	CLINIC	90.00	0	33.26
33.27	OTHER OPERATING REVENUE	B	600	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.27
33.28	BROMENN MEDICAL DIRECTORSHIP	A	-9,000	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.)		-264,901				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 01/01/2020
To 06/30/2020

Worksheet A-8-1

Date/Time Prepared:
11/25/2020 11:20 am

	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	5,014	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	EQUIPMENT	62,568	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EH&W	206,069	0	3.00
4.00	5.01	OTHER ADMINISTRATIVE AND GEN	A&G	128,119	0	4.00
4.03	5.02	OTHER ADMINISTRATIVE AND GEN	A&G	873,451	1,377,439	4.03
4.04	7.00	OPERATION OF PLANT	PLANT OPERATIONS	13,339	0	4.04
4.05	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	12,846	0	4.05
4.06	15.00	PHARMACY	PHARMACY	7,075	0	4.06
4.07	60.00	LABORATORY	LAB	11,035	0	4.07
4.09	30.00	ADULTS & PEDIATRICS	ADULTS & PEDS	24,588	0	4.09
4.10	50.00	OPERATING ROOM	OR	9,129	0	4.10
4.11	91.00	EMERGENCY	ER	10,000	0	4.11
4.12	0.00			0	0	4.12
4.13	0.00			0	0	4.13
4.14	0.00			0	0	4.14
4.15	0.00			0	0	4.15
5.00	0		0	1,363,233	1,377,439	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:					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 01/01/2020
To 06/30/2020

Worksheet A-8-1

Date/Time Prepared:
11/25/2020 11:20 am

	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	5,014	9		1.00
2.00	62,568	9		2.00
3.00	206,069	9		3.00
4.00	128,119	0		4.00
4.03	-503,988	0		4.03
4.04	13,339	0		4.04
4.05	12,846	0		4.05
4.06	7,075	0		4.06
4.07	11,035	0		4.07
4.09	24,588	0		4.09
4.10	9,129	0		4.10
4.11	10,000	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	-14,206			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 01/01/2020
To 06/30/2020

Worksheet A-8-2

Date/Time Prepared:
11/25/2020 11:20 am

	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	91.00	EMERGENCY	740,046	417,765	322,281	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		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			740,046	417,765	322,281			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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		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	91.00	EMERGENCY	0	0	0	417,765		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		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	417,765		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/25/2020 11:20 am

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	136,844	136,844			1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION	274,966	0	274,966		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	291,335		291,335		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	888,865	0	0	888,865	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	438,357	2,813	0	33,442	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	1,501,380	17,616	5,832	21,290	5.02
7.00	00700	OPERATION OF PLANT	412,542	8,551	46,093	10,457	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,692	1,300	0	1,970	8.00
9.00	00900	HOUSEKEEPING	132,587	1,180	1,077	20,426	9.00
10.00	01000	DIETARY	91,318	7,951	0	14,325	10.00
13.00	01300	NURSING ADMINISTRATION	0	1,103	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	39,366	0	0	7,122	14.00
15.00	01500	PHARMACY	83,902	0	0	22,170	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	133,088	6,349	0	23,801	16.00
17.00	01700	SOCIAL SERVICE	120,306	867	0	19,043	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	523,974	14,010	107,925	28,991	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	265,583	9,681	108,784	100,339	50.00
53.00	05300	ANESTHESIOLOGY	138,335	0	0	25,240	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	487,849	13,469	3,230	87,746	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	490,960	4,388	0	6,638	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	88,635	0	0	15,851	64.00
65.00	06500	RESPIRATORY THERAPY	67,786	0	0	6,784	65.00
66.00	06600	PHYSICAL THERAPY	216,162	5,173	0	39,735	66.00
67.00	06700	OCCUPATIONAL THERAPY	56,390	5,169	0	10,303	67.00
68.00	06800	SPEECH PATHOLOGY	8,592	5,320	0	1,581	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	92,231	1,196	2,025	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,680	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	130,628	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,509,950	0	0	212,237	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	570,651	0	0	87,312	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	1,221	90.00
91.00	09100	EMERGENCY	800,168	18,366	0	67,609	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)	10,022,122	124,502	274,966	291,335	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	10,284	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	205	0	0	37	194.03
194.04	07954	SCHOOL THERAPY	44	0	0	8	194.04
194.05	07955	VACANT SPACE	0	2,058	0	0	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)	10,022,371	136,844	274,966	291,335	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/25/2020 11:20 am

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	474,612	474,612				5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	1,549,656	102,795	1,652,451	1,652,451		5.02
7.00	00700	OPERATION OF PLANT	500,625	33,208	533,833	105,393	639,226	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,962	1,921	30,883	6,097	4,712	8.00
9.00	00900	HOUSEKEEPING	157,303	10,434	167,737	33,116	9,663	9.00
10.00	01000	DIETARY	114,222	7,577	121,799	24,046	28,820	10.00
13.00	01300	NURSING ADMINISTRATION	1,103	73	1,176	232	3,997	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	48,672	3,229	51,901	10,247	0	14.00
15.00	01500	PHARMACY	117,390	7,787	125,177	24,713	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	163,238	10,828	174,066	34,365	23,014	16.00
17.00	01700	SOCIAL SERVICE	140,216	9,301	149,517	29,519	3,141	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	764,602	50,718	815,320	160,966	168,881	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	531,031	35,225	566,256	111,794	154,113	50.00
53.00	05300	ANESTHESIOLOGY	163,575	10,850	174,425	34,436	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	657,530	43,616	701,146	138,425	52,353	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	547,305	36,304	583,609	115,220	15,904	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	104,486	6,931	111,417	21,997	0	64.00
65.00	06500	RESPIRATORY THERAPY	76,525	5,076	81,601	16,110	0	65.00
66.00	06600	PHYSICAL THERAPY	263,865	17,503	281,368	55,550	18,750	66.00
67.00	06700	OCCUPATIONAL THERAPY	71,862	4,767	76,629	15,129	18,736	67.00
68.00	06800	SPEECH PATHOLOGY	15,833	1,050	16,883	3,333	19,283	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	95,452	6,332	101,784	20,095	6,549	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,680	244	3,924	775	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	130,628	8,665	139,293	27,500	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,722,187	0	1,722,187	340,010	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	657,963	0	657,963	129,900	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,221	81	1,302	257	0	90.00
91.00	09100	EMERGENCY	905,991	60,097	966,088	190,732	66,573	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)	10,009,735	474,612	10,009,735	1,649,957	594,489	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	10,284	0	10,284	2,030	37,276	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	242	0	242	48	0	194.03
194.04	07954	SCHOOL THERAPY	52	0	52	10	0	194.04
194.05	07955	VACANT SPACE	2,058	0	2,058	406	7,461	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)	10,022,371	474,612	10,022,371	1,652,451	639,226	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020Worksheet B
Part I
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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	41,692					8.00
9.00	00900	HOUSEKEEPING	13,677	224,193				9.00
10.00	01000	DIETARY	0	11,295	185,960			10.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	5,405		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	62,148	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,967	0	0	71	16.00
17.00	01700	SOCIAL SERVICE	0	2,865	0	274	2	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,115	33,830	185,960	1,800	110	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	2,013	25,125	0	1,040	263	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	173	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,376	35,263	0	119	373	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	8,871	0	0	29,000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	6,612	0	415	949	64.00
65.00	06500	RESPIRATORY THERAPY	215	2,645	0	131	65	65.00
66.00	06600	PHYSICAL THERAPY	1,612	8,761	0	60	71	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,984	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	220	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	937	0	0	29,350	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,171	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	39,450	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	37	0	90.00
91.00	09100	EMERGENCY	7,684	42,368	0	1,355	713	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)	41,692	224,193	185,960	5,404	62,138	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	1	10	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)	41,692	224,193	185,960	5,405	62,148	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1309

Period:
From 01/01/2020
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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	149,890					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	235,483				16.00
17.00	01700	SOCIAL SERVICE	0	0	185,318			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,674	235,483	185,318	0	1,807,457	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	8,778	0	0	0	869,382	50.00
53.00	05300	ANESTHESIOLOGY	1,049	0	0	0	210,083	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,074	0	0	0	937,129	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	25	0	0	0	752,629	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	1,998	0	0	0	143,388	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	100,767	65.00
66.00	06600	PHYSICAL THERAPY	1,632	0	0	0	367,804	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	112,478	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	39,719	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	158,715	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,870	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	99,421	0	0	0	266,214	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	2,062,197	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	0	0	827,313	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	1,596	90.00
91.00	09100	EMERGENCY	24,239	0	0	0	1,299,752	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)	149,890	235,483	185,318	0	9,962,493	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	49,590	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	301	194.03
194.04	07954	SCHOOL THERAPY	0	0	0	0	62	194.04
194.05	07955	VACANT SPACE	0	0	0	0	9,925	194.05
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	149,890	235,483	185,318	0	10,022,371	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1309

Period:
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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	1,807,457	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	869,382	50.00
53.00	05300	ANESTHESIOLOGY	0	210,083	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	937,129	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	752,629	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	143,388	64.00
65.00	06500	RESPIRATORY THERAPY	0	100,767	65.00
66.00	06600	PHYSICAL THERAPY	0	367,804	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	112,478	67.00
68.00	06800	SPEECH PATHOLOGY	0	39,719	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	158,715	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,870	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	266,214	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	2,062,197	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	827,313	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	1,596	90.00
91.00	09100	EMERGENCY	0	1,299,752	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			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	9,962,493	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	49,590	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	301	194.03
194.04	07954	SCHOOL THERAPY	0	62	194.04
194.05	07955	VACANT SPACE	0	9,925	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	10,022,371	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Period:
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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	2,813	0	2,813	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	102,148	17,616	5,832	3,538	129,134 5.02
7.00	00700	OPERATION OF PLANT	0	8,551	46,093	22,982	77,626 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,300	0	1,300	8.00
9.00	00900	HOUSEKEEPING	0	1,180	1,077	2,033	4,290 9.00
10.00	01000	DIETARY	0	7,951	0	628	8,579 10.00
13.00	01300	NURSING ADMINISTRATION	0	1,103	0	0	1,103 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	2,184	2,184 14.00
15.00	01500	PHARMACY	0	0	0	11,318	11,318 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	779	6,349	0	0	7,128 16.00
17.00	01700	SOCIAL SERVICE	0	867	0	0	867 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,924	14,010	107,925	28,991	152,850 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	9,681	108,784	100,339	218,804 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,667	13,469	3,230	87,746	146,112 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	4,388	0	6,638	11,026 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,955	1,955 65.00
66.00	06600	PHYSICAL THERAPY	0	5,173	0	2,795	7,968 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,169	0	0	5,169 67.00
68.00	06800	SPEECH PATHOLOGY	0	5,320	0	340	5,660 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,196	2,025	0	3,221 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	108,764	0	0	0	108,764 88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	1,841	0	0	0	1,841 88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	18,366	0	19,848	38,214 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)	257,123	124,502	274,966	291,335	947,926 118.00
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	10,284	0	0	10,284 192.00
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	2,058	0	0	2,058 194.05
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)	257,123	136,844	274,966	291,335	960,268 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/25/2020 11:20 am

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	2,813				5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	0	613	129,747			5.02
7.00	00700	OPERATION OF PLANT	0	197	8,275	86,098		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11	479	635	2,425	8.00
9.00	00900	HOUSEKEEPING	0	62	2,600	1,301	796	9.00
10.00	01000	DIETARY	0	45	1,888	3,882	0	10.00
13.00	01300	NURSING ADMINISTRATION	0	0	18	538	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	19	805	0	0	14.00
15.00	01500	PHARMACY	0	46	1,940	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	64	2,698	3,100	0	16.00
17.00	01700	SOCIAL SERVICE	0	55	2,318	423	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	300	12,639	22,746	646	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	209	8,778	20,758	117	50.00
53.00	05300	ANESTHESIOLOGY	0	64	2,704	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	258	10,869	7,051	313	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	215	9,047	2,142	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	41	1,727	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	30	1,265	0	12	65.00
66.00	06600	PHYSICAL THERAPY	0	104	4,362	2,526	94	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	28	1,188	2,524	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	6	262	2,597	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	38	1,578	882	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1	61	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	51	2,159	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	26,695	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	10,200	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	20	0	0	90.00
91.00	09100	EMERGENCY	0	356	14,976	8,967	447	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	2,813	129,551	80,072	2,425	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	159	5,021	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	0	0	194.03
194.04	07954	SCHOOL THERAPY	0	0	1	0	0	194.04
194.05	07955	VACANT SPACE	0	0	32	1,005	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	2,813	129,747	86,098	2,425	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/25/2020 11:20 am

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	9,049					9.00
10.00	01000	DIETARY	456	14,850				10.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,659			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	3,008		14.00
15.00	01500	PHARMACY	0	0	0	0	13,304	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	160	0	0	3	0	16.00
17.00	01700	SOCIAL SERVICE	116	0	84	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	1,365	14,850	554	5	770	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	1,014	0	319	13	779	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53	0	93	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,423	0	37	18	362	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	358	0	0	1,404	2	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	267	0	127	46	177	64.00
65.00	06500	RESPIRATORY THERAPY	107	0	40	3	0	65.00
66.00	06600	PHYSICAL THERAPY	354	0	18	3	145	66.00
67.00	06700	OCCUPATIONAL THERAPY	80	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	9	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	38	0	0	1,422	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	57	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	8,825	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)	1,592	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	11	0	0	90.00
91.00	09100	EMERGENCY	1,710	0	416	34	2,151	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)	9,049	14,850	1,659	3,008	13,304	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)	9,049	14,850	1,659	3,008	13,304	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/25/2020 11:20 am

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	13,153					16.00
17.00	01700	SOCIAL SERVICE	0	3,863				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,153	3,863		223,741	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		250,791	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0		2,914	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		166,443	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		24,194	0	60.00
60.01	06001	BLOOD LABORATORY	0	0		0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0		2,385	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0		3,412	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0		15,574	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		8,989	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0		8,534	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		7,179	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		119	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		11,035	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0		135,459	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0		13,633	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89.00
90.00	09000	CLINIC	0	0		31	0	90.00
91.00	09100	EMERGENCY	0	0		67,271	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)	13,153	3,863	0	941,704	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		15,464	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		4	0	194.03
194.04	07954	SCHOOL THERAPY	0	0		1	0	194.04
194.05	07955	VACANT SPACE	0	0		3,095	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)	13,153	3,863	0	960,268	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/25/2020 11:20 am

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	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	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 01/01/2020
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/25/2020 11:20 am

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	4.00	5A.01	
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			207,935		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	4,508,586		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	727	0	169,630	-474,612	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	4,553	455	107,988	0	5.02
7.00	00700	OPERATION OF PLANT	2,210	3,596	53,040	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	336	0	9,994	0	8.00
9.00	00900	HOUSEKEEPING	305	84	103,609	0	9.00
10.00	01000	DIETARY	2,055	0	72,661	0	10.00
13.00	01300	NURSING ADMINISTRATION	285	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	36,127	0	14.00
15.00	01500	PHARMACY	0	0	112,451	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,641	0	120,727	0	16.00
17.00	01700	SOCIAL SERVICE	224	0	96,590	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,621	8,420	454,997	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	2,502	8,487	236,593	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	128,025	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,481	252	330,896	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	1,134	0	229,870	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	80,403	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	34,412	0	65.00
66.00	06600	PHYSICAL THERAPY	1,337	0	201,549	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,336	0	52,259	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,375	0	8,021	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	309	158	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	1,076,508	-1,722,187	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	442,875	-657,963	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	6,194	0	90.00
91.00	09100	EMERGENCY	4,747	0	342,936	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	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)	32,178	21,452	207,935	-2,854,762	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	2,658	0	0	-10,284	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	190	-242	194.03
194.04	07954	SCHOOL THERAPY	0	0	41	-52	194.04
194.05	07955	VACANT SPACE	532	0	0	-2,058	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)	136,844	274,966	291,335	888,865	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/25/2020 11:20 am

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	4.00	5A.01	
203.00	Unit cost multiplier (Wkst. B, Part I)	3.869147	12.817733	1.401087	0.197149		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 01/01/2020
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/25/2020 11:20 am

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	7,154,973					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	1,549,656	-1,652,451	8,369,920			5.02
7.00	00700	OPERATION OF PLANT	500,625	0	533,833	45,580		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,962	0	30,883	336	20,976	8.00
9.00	00900	HOUSEKEEPING	157,303	0	167,737	689	6,881	9.00
10.00	01000	DIETARY	114,222	0	121,799	2,055	0	10.00
13.00	01300	NURSING ADMINISTRATION	1,103	0	1,176	285	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	48,672	0	51,901	0	0	14.00
15.00	01500	PHARMACY	117,390	0	125,177	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	163,238	0	174,066	1,641	0	16.00
17.00	01700	SOCIAL SERVICE	140,216	0	149,517	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	764,602	0	815,320	12,042	5,592	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	531,031	0	566,256	10,989	1,013	50.00
53.00	05300	ANESTHESIOLOGY	163,575	0	174,425	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	657,530	0	701,146	3,733	2,705	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	547,305	0	583,609	1,134	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	104,486	0	111,417	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	76,525	0	81,601	0	108	65.00
66.00	06600	PHYSICAL THERAPY	263,865	0	281,368	1,337	811	66.00
67.00	06700	OCCUPATIONAL THERAPY	71,862	0	76,629	1,336	0	67.00
68.00	06800	SPEECH PATHOLOGY	15,833	0	16,883	1,375	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	95,452	0	101,784	467	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,680	0	3,924	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	130,628	0	139,293	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	1,722,187	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	657,963	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,221	0	1,302	0	0	90.00
91.00	09100	EMERGENCY	905,991	0	966,088	4,747	3,866	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)	7,154,973	-1,652,451	8,357,284	42,390	20,976	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	10,284	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	242	0	0	194.03
194.04	07954	SCHOOL THERAPY	0	0	52	0	0	194.04
194.05	07955	VACANT SPACE	0	0	2,058	532	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)	474,612		1,652,451	639,226	41,692	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.066333		0.197427	14.024265	1.987605	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/25/2020 11:20 am

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)	2,813		129,747	86,098	2,425	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000393		0.015502	1.888943	0.115608	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 01/01/2020
To 06/30/2020

Worksheet B-1

Date/Time Prepared:

11/25/2020 11:20 am

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	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	4,069					9.00
10.00	01000	DIETARY	205	200				10.00
13.00	01300	NURSING ADMINISTRATION	0	0	34,136			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	195,284		14.00
15.00	01500	PHARMACY	0	0	0	0	41,870	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	72	0	0	223	0	16.00
17.00	01700	SOCIAL SERVICE	52	0	1,731	5	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	614	200	11,369	346	2,423	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	456	0	6,570	825	2,452	50.00
53.00	05300	ANESTHESIOLOGY	0	0	1,092	0	293	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	640	0	754	1,171	1,138	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	161	0	0	91,125	7	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	120	0	2,619	2,981	558	64.00
65.00	06500	RESPIRATORY THERAPY	48	0	827	204	0	65.00
66.00	06600	PHYSICAL THERAPY	159	0	380	223	456	66.00
67.00	06700	OCCUPATIONAL THERAPY	36	0	0	1	0	67.00
68.00	06800	SPEECH PATHOLOGY	4	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17	0	0	92,231	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,680	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	27,772	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)	716	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	232	0	0	90.00
91.00	09100	EMERGENCY	769	0	8,558	2,239	6,771	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)	4,069	200	34,132	195,254	41,870	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)	224,193	185,960	5,405	62,148	149,890	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	55.097813	929.800000	0.158337	0.318244	3.579890	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
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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)	9,049	14,850	1,659	3,008	13,304	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.223888	74.250000	0.048600	0.015403	0.317745	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 01/01/2020
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
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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	0		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	0		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	0		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)	235,483	185,318	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,177.415000	1,853.180000	0.000000		203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
11/25/2020 11:20 am

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)	13,153	3,863	0		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	65.765000	38.630000	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 01/01/2020
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/25/2020 11:20 am

			Title XVIII	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,807,457		1,807,457	0
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0
41.00	04100	SUBPROVIDER - IRF	0		0	0
42.00	04200	SUBPROVIDER	0		0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	869,382		869,382	0
53.00	05300	ANESTHESIOLOGY	210,083		210,083	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	937,129		937,129	0
57.00	05700	CT SCAN	0		0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0
59.00	05900	CARDIAC CATHETERIZATION	0		0	0
60.00	06000	LABORATORY	752,629		752,629	0
60.01	06001	BLOOD LABORATORY	0		0	0
64.00	06400	INTRAVENOUS THERAPY	143,388		143,388	0
65.00	06500	RESPIRATORY THERAPY	100,767	0	100,767	0
66.00	06600	PHYSICAL THERAPY	367,804	0	367,804	0
67.00	06700	OCCUPATIONAL THERAPY	112,478	0	112,478	0
68.00	06800	SPEECH PATHOLOGY	39,719	0	39,719	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	158,715		158,715	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,870		5,870	0
73.00	07300	DRUGS CHARGED TO PATIENTS	266,214		266,214	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,062,197		2,062,197	0
88.01	08801	RURAL HEALTH CLINIC (RHC)	827,313		827,313	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0
90.00	09000	CLINIC	1,596		1,596	0
91.00	09100	EMERGENCY	1,299,752		1,299,752	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	177,049		177,049	0
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0	0
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0	0
110.00	11000	INTESTINAL ACQUISITION	0		0	0
111.00	11100	ISLET ACQUISITION	0		0	0
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	10,139,542	0	10,139,542	0
201.00		Less Observation Beds	177,049		177,049	0
202.00		Total (see instructions)	9,962,493	0	9,962,493	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/25/2020 11:20 am

			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	392,938		392,938			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	552,003	552,003	1.574959	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	117,127	117,127	1.793634	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	217,874	2,630,482	2,848,356	0.329007	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	396,182	1,974,979	2,371,161	0.317409	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	108,685	108,685	1.319299	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	16,092	163,757	179,849	0.560287	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	123,906	263,557	387,463	0.949262	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,305	69,177	101,482	1.108354	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	5,060	3,014	8,074	4.919371	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,090	31,591	82,681	1.919607	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,012	5,012	1.171189	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	703,224	534,162	1,237,386	0.215142	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,866,079	1,866,079			88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	742,416	742,416			88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	9,980	9,980	0.159920	0.000000	90.00
91.00	09100	EMERGENCY	123,279	1,629,533	1,752,812	0.741524	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	15,184	63,080	78,264	2.262202	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)	2,077,134	10,764,634	12,841,768			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,077,134	10,764,634	12,841,768			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/25/2020 11:20 am

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 01/01/2020
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/25/2020 11:20 am

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total 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	1,807,457		1,807,457	0	1,807,457	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	869,382		869,382	0	869,382	50.00
53.00	05300	ANESTHESIOLOGY	210,083		210,083	0	210,083	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	937,129		937,129	0	937,129	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	752,629		752,629	0	752,629	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	143,388		143,388	0	143,388	64.00
65.00	06500	RESPIRATORY THERAPY	100,767	0	100,767	0	100,767	65.00
66.00	06600	PHYSICAL THERAPY	367,804	0	367,804	0	367,804	66.00
67.00	06700	OCCUPATIONAL THERAPY	112,478	0	112,478	0	112,478	67.00
68.00	06800	SPEECH PATHOLOGY	39,719	0	39,719	0	39,719	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	158,715		158,715	0	158,715	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,870		5,870	0	5,870	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	266,214		266,214	0	266,214	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,062,197		2,062,197	0	2,062,197	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	827,313		827,313	0	827,313	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,596		1,596	0	1,596	90.00
91.00	09100	EMERGENCY	1,299,752		1,299,752	0	1,299,752	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	177,049		177,049	0	177,049	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)	10,139,542	0	10,139,542	0	10,139,542	200.00
201.00		Less Observation Beds	177,049		177,049		177,049	201.00
202.00		Total (see instructions)	9,962,493	0	9,962,493	0	9,962,493	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/25/2020 11:20 am

			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	392,938		392,938		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	552,003	552,003	1.574959	50.00
53.00	05300	ANESTHESIOLOGY	0	117,127	117,127	1.793634	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	217,874	2,630,482	2,848,356	0.329007	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	396,182	1,974,979	2,371,161	0.317409	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	108,685	108,685	1.319299	64.00
65.00	06500	RESPIRATORY THERAPY	16,092	163,757	179,849	0.560287	65.00
66.00	06600	PHYSICAL THERAPY	123,906	263,557	387,463	0.949262	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,305	69,177	101,482	1.108354	67.00
68.00	06800	SPEECH PATHOLOGY	5,060	3,014	8,074	4.919371	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,090	31,591	82,681	1.919607	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,012	5,012	1.171189	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	703,224	534,162	1,237,386	0.215142	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,866,079	1,866,079	1.105096	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	742,416	742,416	1.114352	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	9,980	9,980	0.159920	90.00
91.00	09100	EMERGENCY	123,279	1,629,533	1,752,812	0.741524	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	15,184	63,080	78,264	2.262202	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)	2,077,134	10,764,634	12,841,768		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	2,077,134	10,764,634	12,841,768		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/25/2020 11:20 am

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 01/01/2020
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
11/25/2020 11:20 am

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	250,791	552,003	0.454329	0	0	50.00
53.00	05300 ANESTHESIOLOGY	2,914	117,127	0.024879	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	166,443	2,848,356	0.058435	110,328	6,447	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	24,194	2,371,161	0.010203	168,217	1,716	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	2,385	108,685	0.021944	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	3,412	179,849	0.018971	5,447	103	65.00
66.00	06600 PHYSICAL THERAPY	15,574	387,463	0.040195	17,310	696	66.00
67.00	06700 OCCUPATIONAL THERAPY	8,989	101,482	0.088577	1,660	147	67.00
68.00	06800 SPEECH PATHOLOGY	8,534	8,074	1.056973	330	349	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7,179	82,681	0.086828	19,034	1,653	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	119	5,012	0.023743	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	11,035	1,237,386	0.008918	212,366	1,894	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	135,459	1,866,079	0.072590	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC (RHC)	13,633	742,416	0.018363	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	31	9,980	0.003106	0	0	90.00
91.00	09100 EMERGENCY	67,271	1,752,812	0.038379	12,610	484	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	21,917	78,264	0.280039	0	0	92.00
200.00	Total (lines 50 through 199)	739,880	12,448,830		547,302	13,489	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020

Worksheet D
Part IV
Date/Time Prepared:
11/25/2020 11:20 am

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 01/01/2020
To 06/30/2020

Worksheet D
Part IV
Date/Time Prepared:
11/25/2020 11:20 am

			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	552,003	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	117,127	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,848,356	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	2,371,161	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	108,685	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	179,849	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	387,463	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	101,482	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	8,074	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	82,681	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,012	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,237,386	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,866,079	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	0	742,416	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	9,980	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	1,752,812	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	78,264	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	12,448,830		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/25/2020 11:20 am

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
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	110,328	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	168,217	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	5,447	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	17,310	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,660	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	330	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	19,034	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	212,366	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0.000000	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	12,610	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		547,302	0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/25/2020 11:20 am

			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	1.574959	0	287,139	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	1.793634	0	41,800	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.329007	0	965,963	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	0.317409	0	846,324	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01	
64.00	06400	INTRAVENOUS THERAPY	1.319299	0	29,168	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.560287	0	49,354	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.949262	0	98,384	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	1.108354	0	14,224	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	4.919371	0	355	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.919607	0	7,696	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.171189	0	552	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.215142	0	163,657	0	0	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	0.159920	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.741524	0	379,168	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.262202	0	49,080	0	0	92.00	
200.00		Subtotal (see instructions)		0	2,932,864	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	2,932,864	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/25/2020 11:20 am

			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	452,232	0		50.00
53.00	05300	ANESTHESIOLOGY	74,974	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	317,809	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	268,631	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	38,481	0		64.00
65.00	06500	RESPIRATORY THERAPY	27,652	0		65.00
66.00	06600	PHYSICAL THERAPY	93,392	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	15,765	0		67.00
68.00	06800	SPEECH PATHOLOGY	1,746	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,773	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	646	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,209	0		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	0		90.00
91.00	09100	EMERGENCY	281,162	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	111,029	0		92.00
200.00		Subtotal (see instructions)	1,733,501	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,733,501	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1309

Period:

Worksheet D

Component CCN: 14-Z309

From 01/01/2020
To 06/30/2020

Part IV
Date/Time Prepared:
11/25/2020 11:20 am

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:

Worksheet D

Component CCN: 14-Z309

From 01/01/2020
To 06/30/2020

Part IV
Date/Time Prepared:
11/25/2020 11:20 am

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	552,003	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	117,127	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,848,356	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	2,371,161	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	108,685	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	179,849	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	387,463	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	101,482	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	8,074	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	82,681	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,012	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,237,386	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,866,079	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	0	742,416	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	9,980	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	1,752,812	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	78,264	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	12,448,830		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1309

Period:

Worksheet D

Component CCN: 14-Z309

From 01/01/2020
To 06/30/2020

Part IV
Date/Time Prepared:
11/25/2020 11:20 am

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Cost
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	30,126	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	51,646	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	4,270	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	57,956	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	20,215	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	3,065	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	14,906	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	247,983	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	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		430,167	0	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 01/01/2020
To 06/30/2020Part V
Date/Time Prepared:
11/25/2020 11:20 am

			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	1.574959	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.793634	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.329007	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	0.317409	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	1.319299	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.560287	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.949262	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.108354	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4.919371	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.919607	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.171189	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.215142	0	0	0	0	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	0.159920	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.741524	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.262202	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 01/01/2020
To 06/30/2020Part V
Date/Time Prepared:
11/25/2020 11:20 am

			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				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	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 01/01/2020
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/25/2020 11:20 am

			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	1.574959	0	0	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	1.793634	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.329007	0	35,886	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	0.317409	0	38,721	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01	
64.00	06400	INTRAVENOUS THERAPY	1.319299	0	728	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.560287	0	1,075	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.949262	0	115	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	1.108354	0	980	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	4.919371	0	0	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.919607	0	192	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.171189	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.215142	0	10,721	0	0	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	0.159920	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.741524	0	74,250	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.262202	0	1,120	0	0	92.00	
200.00		Subtotal (see instructions)		0	163,788	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	163,788	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/25/2020 11:20 am

			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	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,807	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	12,290	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	960	0		64.00
65.00	06500	RESPIRATORY THERAPY	602	0		65.00
66.00	06600	PHYSICAL THERAPY	109	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,086	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	369	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,307	0		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	0		90.00
91.00	09100	EMERGENCY	55,058	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,534	0		92.00
200.00		Subtotal (see instructions)	87,122	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	87,122	0		202.00

Health Financial Systems		ADVOCATE EUREKA HOSPITAL		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1309	Period: From 01/01/2020 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/25/2020 11:20 am	
		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)			728	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			298	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)			230	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			394	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			36	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)			178	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)			245	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)			1,807,457	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)			5,724	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)			1,031,566	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			775,891	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)			775,891	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)			2,603.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			463,451	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)			463,451	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
11/25/2020 11:20 am

		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	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)					204,218 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					667,669 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)					637,897 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)					637,897 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)					68 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,603.66 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					177,049 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
11/25/2020 11:20 am

		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	223,741	1,807,457	0.123788	177,049	21,917	90.00
91.00	Nursing School cost	0	1,807,457	0.000000	177,049	0	91.00
92.00	Allied health cost	0	1,807,457	0.000000	177,049	0	92.00
93.00	All other Medical Education	0	1,807,457	0.000000	177,049	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1309	Period: From 01/01/2020 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/25/2020 11:20 am	
			Title XVIII	Hospital	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		223,389		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	1.574959	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.793634	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.329007	110,328	36,299	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	0.317409	168,217	53,394	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	1.319299	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.560287	5,447	3,052	65.00
66.00	06600	PHYSICAL THERAPY	0.949262	17,310	16,432	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.108354	1,660	1,840	67.00
68.00	06800	SPEECH PATHOLOGY	4.919371	330	1,623	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.919607	19,034	36,538	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.171189	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.215142	212,366	45,689	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	0.159920	0	0	90.00
91.00	09100	EMERGENCY	0.741524	12,610	9,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.262202	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		547,302	204,218	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)		547,302		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1309	Period: From 01/01/2020 To 06/30/2020	Worksheet D-3
			Component CCN: 14-Z309		Date/Time Prepared: 11/25/2020 11:20 am
			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	1.574959	0	50.00
53.00	05300	ANESTHESIOLOGY	1.793634	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.329007	30,126	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	0.317409	51,646	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
64.00	06400	INTRAVENOUS THERAPY	1.319299	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.560287	4,270	65.00
66.00	06600	PHYSICAL THERAPY	0.949262	57,956	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.108354	20,215	67.00
68.00	06800	SPEECH PATHOLOGY	4.919371	3,065	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.919607	14,906	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.171189	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.215142	247,983	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	0.159920	0	90.00
91.00	09100	EMERGENCY	0.741524	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.262202	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		430,167	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)		430,167	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1309	Period: From 01/01/2020 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/25/2020 11:20 am	
			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	1.574959	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.793634	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.329007	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	0.317409	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	1.319299	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.560287	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.949262	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.108354	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4.919371	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.919607	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.171189	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.215142	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.105096	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	1.114352	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.159920	0	0	90.00
91.00	09100	EMERGENCY	0.741524	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.262202	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 01/01/2020 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/25/2020 11:20 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,733,501	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)		1,733,501	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		1,750,836	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)		24,039	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		407,202	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)		1,319,595	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)		1,319,595	30.00
31.00	Primary payer payments		459	31.00
32.00	Subtotal (line 30 minus line 31)		1,319,136	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)		91,456	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		59,446	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		60,759	36.00
37.00	Subtotal (see instructions)		1,378,582	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)		1,378,582	40.00
40.01	Sequestration adjustment (see instructions)		18,335	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		789,351	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)		570,896	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 01/01/2020
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
11/25/2020 11:20 am

		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		468,536		789,351	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		468,536		789,351	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		150,991		570,896	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		619,527		1,360,247	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 01/01/2020
To 06/30/2020Part I
Date/Time Prepared:
11/25/2020 11:20 am

		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		624,945		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		624,945		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		212,184		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		837,129		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 01/01/2020
To 06/30/2020Worksheet E-1
Part II
Date/Time Prepared:
11/25/2020 11:20 am

		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 01/01/2020 To 06/30/2020	Worksheet E-2	
		Component CCN: 14-Z309		Date/Time Prepared: 11/25/2020 11:20 am	
		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)		644,276	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)		205,193	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		245	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)		849,469	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		849,469	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)		849,469	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		1,056	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		848,413	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)		848,413	0	19.00
19.01	Sequestration adjustment (see instructions)		11,284	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		624,945	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)		212,184	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparision of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1309	Period: From 01/01/2020 To 06/30/2020	Worksheet E-3 Part V Date/Time Prepared: 11/25/2020 11:20 am
		Title XVIII	Hospital	Cost
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		667,669	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)		667,669	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		674,346	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)		674,346	19.00
20.00	Deductibles (exclude professional component)		52,096	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		622,250	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		622,250	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		8,658	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		5,628	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,411	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		627,878	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)		627,878	30.00
30.01	Sequestration adjustment (see instructions)		8,351	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		468,536	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)		150,991	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 01/01/2020
To 06/30/2020

Worksheet G

Date/Time Prepared:
11/25/2020 11:20 am

	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	1,488,595,000	0	0	0	1.00
2.00 Temporary investments	106,249,000	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	1,399,405,000	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	625,902,000	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)	3,620,151,000	0	0	0	11.00
FIXED ASSETS					
12.00 Land	478,956,000	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	7,865,296,000	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	2,542,542,000	0	0	0	23.00
24.00 Accumulated depreciation	-5,121,020,000	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)	5,765,774,000	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	8,472,465,000	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	1,207,166,000	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	9,679,631,000	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	19,065,556,000	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	1,671,691,000	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)	77,503,000	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	1,304,996,000	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	3,054,190,000	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	3,385,449,000	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	1,872,076,000	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	5,257,525,000	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	8,311,715,000	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	10,753,841,000	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)	10,753,841,000	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	19,065,556,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020

Worksheet G-1

Date/Time Prepared:
11/25/2020 11:20 am

		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		11,698,664,000		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3,020,910				2.00
3.00	Total (sum of line 1 and line 2)		11,695,643,090		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		11,695,643,090		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	ADJ TO AAH FUND BALANCE	941,802,090		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)		941,802,090		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,753,841,000		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			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	ADJ TO AAH FUND BALANCE		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 01/01/2020
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
11/25/2020 11:20 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	291,918		291,918	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	101,020		101,020	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)	392,938		392,938	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)	392,938		392,938	17.00
18.00	Ancillary services	1,762,883	6,129,591	7,892,474	18.00
19.00	Outpatient services	0	2,179,059	2,179,059	19.00
20.00	RURAL HEALTH CLINIC	0	1,866,079	1,866,079	20.00
20.01	RURAL HEALTH CLINIC (RHC)	0	742,416	742,416	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)	2,155,821	10,917,145	13,072,966	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		10,287,272		29.00
30.00	RHC BAD DEBTS REMOVED FROM EXPENSES	141			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)		141		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)		10,287,413		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1309

Period:
From 01/01/2020
To 06/30/2020

Worksheet G-3

Date/Time Prepared:
11/25/2020 11:20 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	13,072,966	1.00
2.00	Less contractual allowances and discounts on patients' accounts	7,353,094	2.00
3.00	Net patient revenues (line 1 minus line 2)	5,719,872	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	10,287,413	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,567,541	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	0	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	25,508	22.00
23.00	Governmental appropriations	94,956	23.00
24.00	OTHER	173,711	24.00
24.50	COVID-19 PHE Funding	1,252,456	24.50
25.00	Total other income (sum of lines 6-24)	1,546,631	25.00
26.00	Total (line 5 plus line 25)	-3,020,910	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)	-3,020,910	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1309

Period:

Worksheet M-1

Component CCN: 14-8581

From 01/01/2020

Date/Time Prepared:

To 06/30/2020

11/25/2020 11:20 am

		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	569,714	0	569,714	0	569,714
2.00	Physician Assistant	33,460	0	33,460	0	33,460
3.00	Nurse Practitioner	28,728	0	28,728	0	28,728
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	109,018	0	109,018	0	109,018
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	115,707	0	115,707	0	115,707
10.00	Subtotal (sum of lines 1 through 9)	856,627	0	856,627	0	856,627
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	85,850	85,850	0	85,850
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	13,120	13,120	0	13,120
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	98,970	98,970	0	98,970
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	856,627	98,970	955,597	0	955,597
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	30,609	30,609	0	30,609
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	30,609	30,609	0	30,609
FACILITY OVERHEAD						
29.00	Facility Costs	0	124,363	124,363	0	124,363
30.00	Administrative Costs	208,840	187,837	396,677	0	396,677
31.00	Total Facility Overhead (sum of lines 29 and 30)	208,840	312,200	521,040	0	521,040
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,065,467	441,779	1,507,246	0	1,507,246

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1309

Period:

Worksheet M-1

Component CCN: 14-8581

From 01/01/2020
To 06/30/2020Date/Time Prepared:
11/25/2020 11:20 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-15,612	554,102	1.00
2.00	Physician Assistant	0	33,460	2.00
3.00	Nurse Practitioner	0	28,728	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	2,247	111,265	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	3,199	118,906	9.00
10.00	Subtotal (sum of lines 1 through 9)	-10,166	846,461	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	63	85,913	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	1,876	1,876	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	13,120	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	1,939	100,909	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-8,227	947,370	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	30,609	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	30,609	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	1,867	126,230	29.00
30.00	Administrative Costs	9,064	405,741	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	10,931	531,971	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,704	1,509,950	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1309

Period:

Worksheet M-1

Component CCN: 14-8582

From 01/01/2020
To 06/30/2020Date/Time Prepared:
11/25/2020 11:20 am

		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	215,444	5,053	220,497	0	220,497 1.00
2.00	Physician Assistant	57,994	0	57,994	0	57,994 2.00
3.00	Nurse Practitioner	10,964	0	10,964	0	10,964 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	37,316	0	37,316	0	37,316 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	15,684	0	15,684	0	15,684 9.00
10.00	Subtotal (sum of lines 1 through 9)	337,402	5,053	342,455	0	342,455 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	25,789	25,789	0	25,789 15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0 16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0 17.00
18.00	Professional Liability Insurance	0	0	0	0	0 18.00
19.00	Other Health Care Costs	0	3,954	3,954	0	3,954 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	29,743	29,743	0	29,743 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	337,402	34,796	372,198	0	372,198 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	3,139	3,139	0	3,139 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	3,139	3,139	0	3,139 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	59,773	59,773	0	59,773 29.00
30.00	Administrative Costs	97,550	61,417	158,967	0	158,967 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	97,550	121,190	218,740	0	218,740 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	434,952	159,125	594,077	0	594,077 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1309

Period:

Worksheet M-1

Component CCN: 14-8582

From 01/01/2020
To 06/30/2020Date/Time Prepared:
11/25/2020 11:20 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	-63,980	156,517		1.00
2.00	Physician Assistant	0	57,994		2.00
3.00	Nurse Practitioner	0	10,964		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	177	37,493		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	7,687	23,371		9.00
10.00	Subtotal (sum of lines 1 through 9)	-56,116	286,339		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	63	25,852		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	9,400	9,400		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	3,954		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	9,463	39,206		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-46,653	325,545		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	3,139		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	3,139		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	23,312	83,085		29.00
30.00	Administrative Costs	-85	158,882		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	23,227	241,967		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-23,426	570,651		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1309

Period:

Worksheet M-2

Component CCN: 14-8581

From 01/01/2020
To 06/30/2020Date/Time Prepared:
11/25/2020 11:20 am

				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	3.62	5,651	2,100	7,602		1.00
2.00	Physician Assistant	0.43	482	1,050	452		2.00
3.00	Nurse Practitioner	0.40	284	1,050	420		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.45	6,417		8,474	8,474	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.45	6,417			8,474	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					947,370	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					30,609	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					977,979	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.968702	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					531,971	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					552,247	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,084,218	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,084,218	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,050,284	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,997,654	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1309

Period:

Worksheet M-2

Component CCN: 14-8582

From 01/01/2020
To 06/30/2020Date/Time Prepared:
11/25/2020 11:20 am

				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	0.93	1,432	2,100	1,953		1.00
2.00	Physician Assistant	0.90	1,146	1,050	945		2.00
3.00	Nurse Practitioner	0.18	119	1,050	189		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.01	2,697		3,087	3,087	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)	2.01	2,697			3,087	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					325,545	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					3,139	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					328,684	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.990450	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					241,967	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					256,662	15.00
16.00	Total overhead (sum of lines 14 and 15)					498,629	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					498,629	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					493,867	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					819,412	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 01/01/2020 To 06/30/2020	Worksheet M-3	
		Component CCN: 14-8581		Date/Time Prepared: 11/25/2020 11:20 am	
		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)			1,997,654	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			49,675	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,947,979	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,474	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			8,474	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			229.88	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)		229.88	229.88	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,977	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	454,473	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	454,473	16.00
16.01	Total program charges (see instructions)(from contractor's records)			455,848	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			827	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			824	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.)			298,908	16.04
16.05	Total program cost (see instructions)		0	299,732	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			80,014	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			75,120	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			299,732	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			19,971	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			319,703	22.00
23.00	Allowable bad debts (see instructions)			76	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			49	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)			319,752	26.00
26.01	Sequestration adjustment (see instructions)			4,253	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			284,861	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)			30,638	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 01/01/2020 To 06/30/2020	Worksheet M-3	
		Component CCN: 14-8582		Date/Time Prepared: 11/25/2020 11:20 am	
		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)			819,412	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			7,906	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			811,506	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,087	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			3,087	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			262.88	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)		262.88	262.88	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	822	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	216,087	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	216,087	16.00
16.01	Total program charges (see instructions)(from contractor's records)			204,801	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.)			154,794	16.04
16.05	Total program cost (see instructions)		0	154,794	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			22,595	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			36,336	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			154,794	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			2,510	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			157,304	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)			157,304	26.00
26.01	Sequestration adjustment (see instructions)			2,092	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			112,362	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)			42,850	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 01/01/2020 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 11/25/2020 11:20 am	
		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)		846,461	846,461	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001171	0.001354	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		991	1,146	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		20,847	574	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		21,838	1,720	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		947,370	947,370	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,050,284	1,050,284	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.023051	0.001816	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		24,210	1,907	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		46,048	3,627	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		96	111	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		479.67	32.68	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		40	24	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		19,187	784	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			49,675	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)			19,971	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1309 Component CCN: 14-8582	Period: From 01/01/2020 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 11/25/2020 11:20 am	
		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)		286,339	286,339	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001089	0.000766	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		312	219	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		2,423	187	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		2,735	406	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		325,545	325,545	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		493,867	493,867	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.008401	0.001247	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		4,149	616	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		6,884	1,022	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		27	19	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		254.96	53.79	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		9	4	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		2,295	215	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)			7,906	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)			2,510	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 01/01/2020 To 06/30/2020	Worksheet M-5 Date/Time Prepared: 11/25/2020 11:20 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		284,861	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01			0	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		284,861	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		30,638	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		315,499	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 01/01/2020 To 06/30/2020	Worksheet M-5 Date/Time Prepared: 11/25/2020 11:20 am	
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			112,362	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			112,362	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			42,850	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			155,212	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00