

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0160	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/25/2020 9:08 am
--	-----------------------	---	--

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/25/2020	Time: 9:08 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	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FHN MEMORIAL HOSPITAL (14-0160) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) MIKE CLARK
Officer or Administrator of Provider(s)

EXECUTIVE VICE PRESIDENT AND CFO
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	-174,796	14,297	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-174,796	14,297	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: 14-0160		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/25/2020 9:08 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1405 WEST STEPHENSON STREET			PO Box:				1.00	
2.00	City: FREEPORT			State: IL		Zip Code: 64032		County: STEPHENSON 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			FHN MEMORIAL HOSPITAL	140160	99914	1	07/01/1966	N P O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
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			FHN MEMORIAL - HOSPICE	141560	99914		08/12/1993	
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2019	12/31/2019	20.00
21.00	Type of Control (see instructions)						2		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.					Y	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)					Y	Y		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.					1	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			2,061	544	31	9	0	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0160		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/25/2020 9:08 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		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					1			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					01/01/2019	12/31/2019		38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? 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			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
					1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
8/25/2020 9:08 am

	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)				0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00	2.00	3.00	4.00		
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
8/25/2020 9:08 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0160	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/25/2020 9:08 am	
			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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.	N	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.	N	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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.	N	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			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)	N			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)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0160		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/25/2020 9:08 am	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00	
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
						1.00	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
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				115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	0	0	603,732	118.01		
						1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N Y				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.	N				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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0160		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/25/2020 9:08 am	
		1.00		2.00			
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				140.00	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		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.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			N		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)			9.99		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0160	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/25/2020 9:08 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0160		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part II Date/Time Prepared: 8/25/2020 9:08 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	06/16/2020	Y	06/16/2020		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: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/25/2020 9:08 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	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				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.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				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.				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.				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.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID	MCCLUNG		41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	641-494-2144	DAVID.MCCLUNG@RSMUS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/25/2020 9:08 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.	MANAGER	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: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/25/2020 9:08 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	92	33,580	0.00	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)		92	33,580	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		100	36,500	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		100				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: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/25/2020 9:08 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)	5,555	2,146	12,446		1.00
2.00	HMO and other (see instructions)	3,399	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	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,555	2,146	12,446		7.00
8.00	INTENSIVE CARE UNIT	504	111	1,328		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		388	622		13.00
14.00	Total (see instructions)	6,059	2,645	14,396	0.00	532.07
15.00	CAH visits	0	0	0		14.00
16.00	SUBPROVIDER - IPF					15.00
17.00	SUBPROVIDER - IRF					16.00
18.00	SUBPROVIDER					17.00
19.00	SKILLED NURSING FACILITY					18.00
20.00	NURSING FACILITY					19.00
21.00	OTHER LONG TERM CARE					20.00
22.00	HOME HEALTH AGENCY					21.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					22.00
24.00	HOSPICE	0	0	0	0.00	23.00
24.10	HOSPICE (non-distinct part)			0		18.55
25.00	CMHC - CMHC					24.00
26.00	RURAL HEALTH CLINIC					24.10
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	25.00
27.00	Total (sum of lines 14-26)				0.00	0.00
28.00	Observation Bed Days		0	4,680		550.62
29.00	Ambulance Trips	0				26.00
30.00	Employee discount days (see instruction)			0		26.25
31.00	Employee discount days - IRF			0		27.00
32.00	Labor & delivery days (see instructions)	0	0	163		28.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		29.00
33.00	LTCH non-covered days	0				30.00
33.01	LTCH site neutral days and discharges	0				31.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/25/2020 9:08 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	1,451	716	3,753	1.00
2.00 HMO and other (see instructions)			841	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	1,451	716	3,753	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/25/2020 9:08 am

	Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	35,936,889	0	35,936,889	1,132,377.00	31.74 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non Physician-Part B		2,306,190	0	2,306,190	24,055.83	95.87 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		1,031,742	16,045	1,047,787	39,347.54	26.63 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,636,880	0	1,636,880	26,781.16	61.12 11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		5,000	0	5,000	90.75	55.10 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		0	0	0	0.00	0.00 14.01
14.02	Related organization salaries		4,333,580	0	4,333,580	126,062.00	34.38 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00 16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,223,951	0	8,223,951		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		290,760	0	290,760		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		252,752	0	252,752		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		1,686,119	0	1,686,119		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/25/2020 9:08 am

		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	2,443,881	-10,030	2,433,851	104,118.21	23.38	27.00
28.00	Administrative & General under contract (see inst.)		186,984	0	186,984	1,088.60	171.77	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	316,758	0	316,758	18,699.39	16.94	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,050	0	1,050	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,338,505	0	1,338,505	94,578.16	14.15	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		450,344	0	450,344	27,037.00	16.66	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	658,077	0	658,077	15,832.61	41.56	38.00
39.00	Central Services and Supply	14.00	96,176	0	96,176	6,719.61	14.31	39.00
40.00	Pharmacy	15.00	1,072,660	0	1,072,660	29,651.87	36.18	40.00
41.00	Medical Records & Medical Records Library	16.00	1,463,401	0	1,463,401	51,901.35	28.20	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part III
Date/Time Prepared:
8/25/2020 9:08 am

	Worksheet A Line Number	Amount Reported	Reclassificat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	35,606,532	0	35,606,532	1,231,024.93	28.92	1.00
2.00	Excluded area salaries (see instructions)	1,031,742	16,045	1,047,787	39,347.54	26.63	2.00
3.00	Subtotal salaries (line 1 minus line 2)	34,574,790	-16,045	34,558,745	1,191,677.39	29.00	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,975,460	0	5,975,460	152,933.91	39.07	4.00
5.00	Subtotal wage-related costs (see inst.)	9,910,070	0	9,910,070	0.00	28.68	5.00
6.00	Total (sum of lines 3 thru 5)	50,460,320	-16,045	50,444,275	1,344,611.30	37.52	6.00
7.00	Total overhead cost (see instructions)	8,027,836	-10,030	8,017,806	349,626.80	22.93	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part IV
Date/Time Prepared:
8/25/2020 9:08 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	200,304	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	32,451	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	5,736,772	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	-67,973	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	70,489	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	83,529	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	219,348	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	2,507,197	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	17,797	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,799,914	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part V
Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,636,880	8,799,914	1.00
2.00	Hospital	1,636,880	8,799,914	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA				Provider CCN: 14-0160 Hospice CCN: 14-1560		Period: From 01/01/2019 To 12/31/2019		Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 8/25/2020 9:08 am	
						Hospice I			
		Unduplicated Days							
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)		
		1.00	2.00	3.00	4.00	5.00	6.00		
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015									
1.00	Hospice Continuous Home Care							1.00	
2.00	Hospice Routine Home Care							2.00	
3.00	Hospice Inpatient Respite Care							3.00	
4.00	Hospice General Inpatient Care							4.00	
5.00	Total Hospice Days							5.00	
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015									
6.00	Number of patients receiving hospice care							6.00	
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00	
8.00	Average Length of Stay (line 5 / line 6)							8.00	
9.00	Unduplicated census count							9.00	
NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.									
				Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)		
				1.00	2.00	3.00	4.00		
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015									
10.00	Hospice Continuous Home Care			0	0	0		10.00	
11.00	Hospice Routine Home Care			14,148	278	562	14,988	11.00	
12.00	Hospice Inpatient Respite Care			34	0	1	35	12.00	
13.00	Hospice General Inpatient Care			19	0	8	27	13.00	
14.00	Total Hospice Days			14,201	278	571	15,050	14.00	
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015									
15.00	Hospice Inpatient Respite Care			0	0	0	0	15.00	
16.00	Hospice General Inpatient Care			0	0	0	0	16.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0160	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 8/25/2020 9:08 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)			0.200621 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	9,386,180		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?	N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,956,573		5.00
6.00	Medicaid charges	82,584,661		6.00
7.00	Medicaid cost (line 1 times line 6)	16,568,217		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)	5,225,464		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	74,000		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	5,225,464		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)	3,708,699	0	3,708,699 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	744,043	0	744,043 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	744,043	0	744,043 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	11,334,153		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	931,427		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,432,965		27.01
28.00	Non-Medicare bad debt expense (see instructions)	9,901,188		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,487,924		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,231,967		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	8,457,431		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0160

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

Worksheet A

Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	1,355,210	1,355,210	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,883,347	3,883,347	-1,355,210	2,528,137	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,799,914	8,799,914	0	8,799,914	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,443,881	20,068,699	22,512,580	-11,845	22,500,735	5.00
7.00	00700	OPERATION OF PLANT	316,758	3,422,518	3,739,276	0	3,739,276	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	458,170	458,170	0	458,170	8.00
9.00	00900	HOUSEKEEPING	1,050	1,922,284	1,923,334	0	1,923,334	9.00
10.00	01000	DIETARY	0	2,142,427	2,142,427	-1,139,131	1,003,296	10.00
11.00	01100	CAFETERIA	0	0	0	1,139,131	1,139,131	11.00
13.00	01300	NURSING ADMINISTRATION	658,077	294,752	952,829	0	952,829	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	96,176	377,706	473,882	0	473,882	14.00
15.00	01500	PHARMACY	1,072,660	5,316,235	6,388,895	-4,163,046	2,225,849	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,463,401	749,464	2,212,865	0	2,212,865	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,534,400	1,997,199	12,531,599	-6,550	12,525,049	30.00
31.00	03100	INTENSIVE CARE UNIT	1,225,485	696,108	1,921,593	0	1,921,593	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,260,824	6,513,863	8,774,687	0	8,774,687	50.00
50.01	05001	GI LAB	939,799	909,173	1,848,972	0	1,848,972	50.01
50.02	05002	AMBULATORY CARE UNIT	1,300,892	243,862	1,544,754	0	1,544,754	50.02
51.00	05100	RECOVERY ROOM	483,987	18,174	502,161	0	502,161	51.00
53.00	05300	ANESTHESIOLOGY	0	1,101,423	1,101,423	0	1,101,423	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,290,017	4,652,588	6,942,605	0	6,942,605	54.00
60.00	06000	LABORATORY	1,311,115	3,699,926	5,011,041	0	5,011,041	60.00
65.00	06500	RESPIRATORY THERAPY	805,721	257,057	1,062,778	0	1,062,778	65.00
66.00	06600	PHYSICAL THERAPY	2,425,027	217,856	2,642,883	0	2,642,883	66.00
69.00	06900	ELECTROCARDIOLOGY	224,969	358,855	583,824	0	583,824	69.00
69.01	06901	CATH LAB	515,271	576,703	1,091,974	0	1,091,974	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,163,046	4,163,046	73.00
74.00	07400	RENAL DIALYSIS	0	102,511	102,511	0	102,511	74.00
76.00	03950	DIABETIC EDUCATION	0	72,798	72,798	0	72,798	76.00
76.01	03480	CANCER CENTER	1,401,145	8,035,470	9,436,615	0	9,436,615	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,488	1,331,183	1,336,671	0	1,336,671	90.00
91.00	09100	EMERGENCY	3,129,004	6,579,102	9,708,106	0	9,708,106	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	1,031,742	1,016,288	2,048,030	0	2,048,030	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,936,889	85,815,655	121,752,544	-18,395	121,734,149	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	47	47	0	47	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	0	0	0	11,845	11,845	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPIRE CARE	0	0	0	6,550	6,550	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	35,936,889	85,815,702	121,752,591	0	121,752,591	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0160

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

Worksheet A

Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	1,355,210	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	2,528,137	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,799,914	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,658,136	15,842,599	5.00
7.00	00700	OPERATION OF PLANT	0	3,739,276	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	458,170	8.00
9.00	00900	HOUSEKEEPING	0	1,923,334	9.00
10.00	01000	DIETARY	-9,293	994,003	10.00
11.00	01100	CAFETERIA	-1,613	1,137,518	11.00
13.00	01300	NURSING ADMINISTRATION	-129,133	823,696	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	473,882	14.00
15.00	01500	PHARMACY	0	2,225,849	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,714	2,211,151	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-3,207,315	9,317,734	30.00
31.00	03100	INTENSIVE CARE UNIT	-399,536	1,522,057	31.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-332,813	8,441,874	50.00
50.01	05001	GI LAB	0	1,848,972	50.01
50.02	05002	AMBULATORY CARE UNIT	0	1,544,754	50.02
51.00	05100	RECOVERY ROOM	0	502,161	51.00
53.00	05300	ANESTHESIOLOGY	-978,608	122,815	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,812,548	4,130,057	54.00
60.00	06000	LABORATORY	-475,047	4,535,994	60.00
65.00	06500	RESPIRATORY THERAPY	-65,756	997,022	65.00
66.00	06600	PHYSICAL THERAPY	-86,204	2,556,679	66.00
69.00	06900	ELECTROCARDIOLOGY	-292,036	291,788	69.00
69.01	06901	CATH LAB	-36,000	1,055,974	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,163,046	73.00
74.00	07400	RENAL DIALYSIS	0	102,511	74.00
76.00	03950	DIABETIC EDUCATION	-1,300	71,498	76.00
76.01	03480	CANCER CENTER	-950,223	8,486,392	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	1,336,671	90.00
91.00	09100	EMERGENCY	-5,240,877	4,467,229	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	-11,500	2,036,530	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-21,689,652	100,044,497	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	47	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	0	11,845	192.03
192.04	19204	SMART STEPS	0	0	192.04
192.05	19205	RESPIRE CARE	0	6,550	192.05
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-21,689,652	100,062,939	200.00

Provider CCN: 14-0160

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

Worksheet A-6
Date/Time Prepared:
8/25/2020 9:08 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - CHARGEABLE DRUGS					1.00
	DRUGS CHARGED TO PATIENTS	73.00	0	4,163,046		
	TOTALS		0	4,163,046		
1.00	B - SHARED DIETARY EXPENSES					1.00
	CAFETERIA	11.00	0	1,139,131		
	TOTALS		0	1,139,131		
1.00	C - RESPITE CARE					1.00
	RESPITE CARE	192.05	6,015	535		
	TOTALS		6,015	535		
1.00	D - NON PATIENT VOLUNTEER ADMIN					1.00
	NA VOLUNTEER SERVICES	192.03	10,030	1,815		
	TOTALS		10,030	1,815		
1.00	E - BUILDING DEPRECIATION					1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	1,355,210		
	TOTALS		0	1,355,210		
500.00	Grand Total: Increases			16,045	6,659,737	500.00

RECLASSIFICATIONS

Provider CCN: 14-0160

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

Worksheet A-6

Date/Time Prepared:
8/25/2020 9:08 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - CHARGEABLE DRUGS						1.00
	PHARMACY	15.00	0	4,163,046	0		
	TOTALS		0	4,163,046			
1.00	B - SHARED DIETARY EXPENSES						1.00
	DIETARY	10.00	0	1,139,131	0		
	TOTALS		0	1,139,131			
1.00	C - RESPITE CARE						1.00
	ADULTS & PEDIATRICS	30.00	6,015	535	0		
	TOTALS		6,015	535			
1.00	D - NON PATIENT VOLUNTEER ADMIN						1.00
	ADMINISTRATIVE & GENERAL	5.00	10,030	1,815	0		
	TOTALS		10,030	1,815			
1.00	E - BUILDING DEPRECIATION						1.00
	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,355,210	9		
	TOTALS		0	1,355,210			
500.00	Grand Total: Decreases			16,045	6,659,737		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
8/25/2020 9:08 am

		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	944,945	0	0	0	0	1.00	
2.00	Land Improvements	1,824,213	124,987	0	124,987	0	2.00	
3.00	Buildings and Fixtures	51,674,446	835,267	0	835,267	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	1,358,043	55,495	0	55,495	0	5.00	
6.00	Movable Equipment	35,891,628	61,791	0	61,791	0	6.00	
7.00	HIT designated Assets	3,246,690	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	94,939,965	1,077,540	0	1,077,540	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	94,939,965	1,077,540	0	1,077,540	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	944,945	0				1.00	
2.00	Land Improvements	1,949,200	0				2.00	
3.00	Buildings and Fixtures	52,509,713	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	1,413,538	0				5.00	
6.00	Movable Equipment	35,953,419	0				6.00	
7.00	HIT designated Assets	3,246,690	0				7.00	
8.00	Subtotal (sum of lines 1-7)	96,017,505	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	96,017,505	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,883,347	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,883,347	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,883,347				2.00
3.00	Total (sum of lines 1-2)	0	3,883,347				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	60,064,086	0	60,064,086	0.625553	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	35,953,419	0	35,953,419	0.374447	0	2.00
3.00	Total (sum of lines 1-2)	96,017,505	0	96,017,505	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,355,210	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,528,137	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,883,347	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,355,210	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,528,137	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	3,883,347	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0160

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

Worksheet A-8

Date/Time Prepared:
8/25/2020 9:08 am

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 #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP 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	-15,011,206			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	-2,001,040			0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests			0	0.00	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		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0160

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

Worksheet A-8

Date/Time Prepared:
8/25/2020 9:08 am

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 #		
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TRADE, QUANTITY AND TIME DISCOUNTS	B	-7,725	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	CAFETERIA--EMPLOYEES AND GUESTS	B	0	DIETARY	10.00	0	33.01
33.02	SALE OF DRUGS TO OTHER THAN PATIENTS	B	0	PHARMACY	15.00	0	33.02
33.03	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-1,714	MEDICAL RECORDS & LIBRARY	16.00	0	33.03
33.04	VENDING MACHINES	B	-1,613	CAFETERIA	11.00	0	33.04
33.05	DIETARY REVENUE	B	-190	DIETARY	10.00	0	33.05
33.06	PHYSICIAN COLLECTIONS EXPENSES	A	-80,011	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	DIETARY CONSULTING	B	-483	DIETARY	10.00	0	33.07
33.08	TELEPHONE CAPITAL COSTS	A	-61,633	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	TV CAPITAL COSTS	A	-12,876	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	ASSOC LOBBYING FEES	A	-27,950	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	MEALS ON WHEELS	B	-8,620	DIETARY	10.00	0	33.11
33.12	HBP HOSPICE	A	-11,500	HOSPICE	116.00	0	33.12
33.13	OTHER REVENUE MISC	B	-25,246	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	OB MISC INCOME	B	-103	ADULTS & PEDIATRICS	30.00	0	33.14
33.15	LIFELINE EXPENSE	A	-3,043	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	LIFELINE DEPR		0		0.00	9	33.16
33.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.18
33.19	NONPATIENT DIABETIC REVENUE	B	-1,300	DIABETIC EDUCATION	76.00	0	33.19
33.20	RADIOLOGY MED RECORD REVENUE	B	-85	RADIOLOGY-DIAGNOSTIC	54.00	0	33.20
33.21	PT, OT, SPORTS MED MISC INCOME	B	-2,302	PHYSICAL THERAPY	66.00	0	33.21
33.22	PROVIDER TAX COST	A	-4,430,460	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	MED SURG INCOME	B	-552	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.24
33.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.25
33.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.26
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-21,689,652				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: 14-0160

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

Worksheet A-8-1

Date/Time Prepared:
8/25/2020 9:08 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	5.00	ADMINISTRATIVE & GENERAL	CORPORATE ALLOCATION	10,224,746	12,225,786	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			10,224,746	12,225,786	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	Related Organization(s) and/or Home Office		
				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	A	FREEPORT MEMORI	100.00	FREEPORT 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: 14-0160

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

Worksheet A-8-1

Date/Time Prepared:
8/25/2020 9:08 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	-2,001,040	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-2,001,040			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	HEALTH CARE PARENT CO		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: 14-0160

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

Worksheet A-8-2

Date/Time Prepared:
8/25/2020 9:08 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	30.00	ADULTS & PEDIATRICS	888,522	888,522	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	399,536	399,536	0	0	0	2.00
3.00	50.00	OPERATING ROOM	64,313	64,313	0	0	0	3.00
4.00	13.00	NURSING ADMINISTRATION	129,133	129,133	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	2,812,463	2,812,463	0	0	0	6.00
7.00	60.00	LABORATORY	475,047	475,047	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	292,036	292,036	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	65,756	65,756	0	0	0	9.00
10.00	91.00	EMERGENCY	5,240,877	5,240,877	0	0	0	10.00
11.00	76.01	CANCER CENTER	950,223	950,223	0	0	0	11.00
12.00	30.00	ADULTS & PEDIATRICS	2,306,190	2,306,190	0	0	0	12.00
13.00	5.00	ADMINISTRATIVE & GENERAL	12,600	7,600	5,000	159,800	91	13.00
14.00	30.00	ADULTS & PEDIATRICS	12,500	12,500	0	0	0	14.00
15.00	69.01	CATH LAB	36,000	36,000	0	0	0	15.00
16.00	53.00	ANESTHESIOLOGY	978,608	978,608	0	0	0	16.00
17.00	50.00	OPERATING ROOM	268,500	268,500	0	0	0	17.00
18.00	66.00	PHYSICAL THERAPY	83,902	83,902	0	0	0	18.00
200.00			15,016,206	15,011,206	5,000		91	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
11.00	76.01	CANCER CENTER	0	0	0	0	0	11.00
12.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	12.00
13.00	5.00	ADMINISTRATIVE & GENERAL	6,991	350	0	0	0	13.00
14.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	14.00
15.00	69.01	CATH LAB	0	0	0	0	0	15.00
16.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	16.00
17.00	50.00	OPERATING ROOM	0	0	0	0	0	17.00
18.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	18.00
200.00			6,991	350	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	888,522		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	399,536		2.00
3.00	50.00	OPERATING ROOM	0	0	0	64,313		3.00
4.00	13.00	NURSING ADMINISTRATION	0	0	0	129,133		4.00
5.00	50.00	OPERATING ROOM	0	0	0	0		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	2,812,463		6.00
7.00	60.00	LABORATORY	0	0	0	475,047		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	292,036		8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	65,756		9.00
10.00	91.00	EMERGENCY	0	0	0	5,240,877		10.00
11.00	76.01	CANCER CENTER	0	0	0	950,223		11.00
12.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,306,190		12.00
13.00	5.00	ADMINISTRATIVE & GENERAL	0	6,991	0	7,600		13.00
14.00	30.00	ADULTS & PEDIATRICS	0	0	0	12,500		14.00
15.00	69.01	CATH LAB	0	0	0	36,000		15.00
16.00	53.00	ANESTHESIOLOGY	0	0	0	978,608		16.00
17.00	50.00	OPERATING ROOM	0	0	0	268,500		17.00
18.00	66.00	PHYSICAL THERAPY	0	0	0	83,902		18.00
200.00			0	6,991	0	15,011,206		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,355,210	1,355,210			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,528,137		2,528,137		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,799,914	8,438	0	8,808,352	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,842,599	285,817	121,311	596,551	5.00
7.00	00700	OPERATION OF PLANT	3,739,276	151,577	14,583	77,639	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	458,170	10,156	0	0	8.00
9.00	00900	HOUSEKEEPING	1,923,334	22,282	537	257	9.00
10.00	01000	DIETARY	994,003	50,154	8,858	0	10.00
11.00	01100	CAFETERIA	1,137,518	42,805	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	823,696	1,619	16,210	161,299	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	473,882	3,873	13,926	23,573	14.00
15.00	01500	PHARMACY	2,225,849	10,529	109,219	262,915	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,211,151	18,976	559	358,688	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,317,734	247,046	232,658	2,580,578	30.00
31.00	03100	INTENSIVE CARE UNIT	1,522,057	18,719	22,930	300,374	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,441,874	93,836	294,507	554,142	50.00
50.01	05001	GI LAB	1,848,972	30,270	95,212	230,350	50.01
50.02	05002	AMBULATORY CARE UNIT	1,544,754	39,337	19,257	318,856	50.02
51.00	05100	RECOVERY ROOM	502,161	7,237	13,100	118,628	51.00
53.00	05300	ANESTHESIOLOGY	122,815	3,733	37,779	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,130,057	75,899	513,567	561,297	54.00
60.00	06000	LABORATORY	4,535,994	38,442	308,465	321,362	60.00
65.00	06500	RESPIRATORY THERAPY	997,022	36,850	89,458	197,487	65.00
66.00	06600	PHYSICAL THERAPY	2,556,679	49,223	98,821	594,389	66.00
69.00	06900	ELECTROCARDIOLOGY	291,788	2,843	47,429	55,141	69.00
69.01	06901	CATH LAB	1,055,974	2,699	74,968	126,296	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	4,163,046	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	102,511	1,336	0	0	74.00
76.00	03950	DIABETIC EDUCATION	71,498	1,826	179	0	76.00
76.01	03480	CANCER CENTER	8,486,392	35,982	164,773	343,429	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,336,671	0	10,043	1,345	90.00
91.00	09100	EMERGENCY	4,467,229	59,433	200,673	766,938	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	2,036,530	0	19,115	252,886	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100,044,497	1,350,937	2,528,137	8,804,420	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	47	3,441	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	832	0	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	11,845	0	0	2,458	192.03
192.04	19204	SMART STEPS	0	0	0	0	192.04
192.05	19205	RESPIRE CARE	6,550	0	0	1,474	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	100,062,939	1,355,210	2,528,137	8,808,352	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,846,278					5.00
7.00	00700	OPERATION OF PLANT	806,330	4,789,405				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	94,807	53,488	616,621			8.00
9.00	00900	HOUSEKEEPING	394,029	117,351	0	2,457,790		9.00
10.00	01000	DIETARY	213,171	264,146	0	140,567	1,670,899	10.00
11.00	01100	CAFETERIA	238,943	225,440	0	119,969	0	11.00
13.00	01300	NURSING ADMINISTRATION	203,011	8,528	0	4,538	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	104,308	20,395	0	10,854	0	14.00
15.00	01500	PHARMACY	528,065	55,454	0	29,510	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	524,190	99,940	0	53,184	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,505,775	1,301,118	210,382	692,393	1,574,445	30.00
31.00	03100	INTENSIVE CARE UNIT	377,362	98,590	28,481	52,465	96,454	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,899,760	494,205	17,365	262,993	0	50.00
50.01	05001	GI LAB	446,338	159,421	54,214	84,837	0	50.01
50.02	05002	AMBULATORY CARE UNIT	389,129	207,176	32,623	110,250	0	50.02
51.00	05100	RECOVERY ROOM	129,789	38,114	19,714	20,283	0	51.00
53.00	05300	ANESTHESIOLOGY	33,266	19,661	0	10,463	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,069,044	399,737	82,295	212,722	0	54.00
60.00	06000	LABORATORY	1,053,546	202,462	0	107,741	0	60.00
65.00	06500	RESPIRATORY THERAPY	267,385	194,077	306	103,279	0	65.00
66.00	06600	PHYSICAL THERAPY	667,869	259,243	20,352	137,957	0	66.00
69.00	06900	ELECTROCARDIOLOGY	80,409	14,971	0	7,967	0	69.00
69.01	06901	CATH LAB	255,060	14,213	6,519	7,563	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	842,763	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	21,023	7,035	0	3,744	0	74.00
76.00	03950	DIABETIC EDUCATION	14,880	9,617	0	5,118	0	76.00
76.01	03480	CANCER CENTER	1,828,141	189,505	0	100,846	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	272,900	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,112,255	313,015	144,370	166,572	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	467,337	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,840,885	4,766,902	616,621	2,445,815	1,670,899	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	706	18,121	0	9,643	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	168	4,382	0	2,332	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	2,895	0	0	0	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPIRE CARE	1,624	0	0	0	0	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,846,278	4,789,405	616,621	2,457,790	1,670,899	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,764,675					11.00
13.00	01300	NURSING ADMINISTRATION	26,769	1,245,670				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,409	0	662,220			14.00
15.00	01500	PHARMACY	52,529	0	11,689	3,285,759		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	90,223	0	0	0	3,356,911	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	545,734	862,428	135,094	3,983	216,064	30.00
31.00	03100	INTENSIVE CARE UNIT	55,956	98,605	35,230	856	29,178	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	115,178	0	43,810	221,361	466,228	50.00
50.01	05001	GI LAB	48,821	0	80,987	911	196,993	50.01
50.02	05002	AMBULATORY CARE UNIT	61,923	0	31,348	1,976	12,983	50.02
51.00	05100	RECOVERY ROOM	19,593	0	1,282	739	18,593	51.00
53.00	05300	ANESTHESIOLOGY	0	0	21,488	6,374	54,300	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	148,114	0	53,245	3,239	637,204	54.00
60.00	06000	LABORATORY	87,361	0	29,945	1,481	376,927	60.00
65.00	06500	RESPIRATORY THERAPY	49,183	0	23,604	3,278	92,514	65.00
66.00	06600	PHYSICAL THERAPY	130,457	0	8,883	854	127,257	66.00
69.00	06900	ELECTROCARDIOLOGY	10,038	0	386	0	73,736	69.00
69.01	06901	CATH LAB	23,019	0	410	572	71,274	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,210,221	382,268	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	1,896	74.00
76.00	03950	DIABETIC EDUCATION	0	0	1	0	505	76.00
76.01	03480	CANCER CENTER	54,505	0	21,970	1,774,226	224,374	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	323	0	52,901	7,905	45,274	90.00
91.00	09100	EMERGENCY	166,256	284,637	100,857	2,542	283,436	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	65,833	0	9,090	45,241	45,907	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,763,224	1,245,670	662,220	3,285,759	3,356,911	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	1,048	0	0	0	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPIRE CARE	403	0	0	0	0	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,764,675	1,245,670	662,220	3,285,759	3,356,911	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,425,432	0	20,425,432	30.00
31.00	03100	INTENSIVE CARE UNIT	2,737,257	0	2,737,257	31.00
43.00	04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,905,259	0	12,905,259	50.00
50.01	05001	GI LAB	3,277,326	0	3,277,326	50.01
50.02	05002	AMBULATORY CARE UNIT	2,769,612	0	2,769,612	50.02
51.00	05100	RECOVERY ROOM	889,233	0	889,233	51.00
53.00	05300	ANESTHESIOLOGY	309,879	0	309,879	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,886,420	0	7,886,420	54.00
60.00	06000	LABORATORY	7,063,726	0	7,063,726	60.00
65.00	06500	RESPIRATORY THERAPY	2,054,443	0	2,054,443	65.00
66.00	06600	PHYSICAL THERAPY	4,651,984	0	4,651,984	66.00
69.00	06900	ELECTROCARDIOLOGY	584,708	0	584,708	69.00
69.01	06901	CATH LAB	1,638,567	0	1,638,567	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	6,598,298	0	6,598,298	73.00
74.00	07400	RENAL DIALYSIS	137,545	0	137,545	74.00
76.00	03950	DIABETIC EDUCATION	103,624	0	103,624	76.00
76.01	03480	CANCER CENTER	13,224,143	0	13,224,143	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,727,362	0	1,727,362	90.00
91.00	09100	EMERGENCY	8,068,213	0	8,068,213	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	2,941,939	0	2,941,939	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,994,970	0	99,994,970	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,958	0	31,958	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,714	0	7,714	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	18,246	0	18,246	192.03
192.04	19204	SMART STEPS	0	0	0	192.04
192.05	19205	RESPIRE CARE	10,051	0	10,051	192.05
193.00	19300	NONPAID WORKERS	0	0	0	193.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	100,062,939	0	100,062,939	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,438	0	8,438	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	285,817	121,311	407,128	5.00
7.00	00700	OPERATION OF PLANT	0	151,577	14,583	166,160	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,156	0	10,156	8.00
9.00	00900	HOUSEKEEPING	0	22,282	537	22,819	9.00
10.00	01000	DIETARY	0	50,154	8,858	59,012	10.00
11.00	01100	CAFETERIA	0	42,805	0	42,805	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,619	16,210	17,829	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,873	13,926	17,799	14.00
15.00	01500	PHARMACY	0	10,529	109,219	119,748	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,976	559	19,535	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	247,046	232,658	479,704	30.00
31.00	03100	INTENSIVE CARE UNIT	0	18,719	22,930	41,649	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	93,836	294,507	388,343	50.00
50.01	05001	GI LAB	0	30,270	95,212	125,482	50.01
50.02	05002	AMBULATORY CARE UNIT	0	39,337	19,257	58,594	50.02
51.00	05100	RECOVERY ROOM	0	7,237	13,100	20,337	51.00
53.00	05300	ANESTHESIOLOGY	0	3,733	37,779	41,512	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	75,899	513,567	589,466	54.00
60.00	06000	LABORATORY	0	38,442	308,465	346,907	60.00
65.00	06500	RESPIRATORY THERAPY	0	36,850	89,458	126,308	65.00
66.00	06600	PHYSICAL THERAPY	0	49,223	98,821	148,044	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,843	47,429	50,272	69.00
69.01	06901	CATH LAB	0	2,699	74,968	77,667	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
74.00	07400	RENAL DIALYSIS	0	1,336	0	1,336	74.00
76.00	03950	DIABETIC EDUCATION	0	1,826	179	2,005	76.00
76.01	03480	CANCER CENTER	0	35,982	164,773	200,755	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	10,043	10,043	90.00
91.00	09100	EMERGENCY	0	59,433	200,673	260,106	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	19,115	19,115	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,350,937	2,528,137	3,879,074	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,441	0	3,441	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	832	0	832	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	0	0	0	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	192.04
192.05	19205	RESPIRE CARE	0	0	0	0	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,355,210	2,528,137	3,883,347	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	407,700					5.00
7.00	00700	OPERATION OF PLANT	19,513	185,747				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,294	2,074	14,524			8.00
9.00	00900	HOUSEKEEPING	9,535	4,551	0	36,905		9.00
10.00	01000	DIETARY	5,159	10,244	0	2,111	76,526	10.00
11.00	01100	CAFETERIA	5,782	8,743	0	1,801	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,913	331	0	68	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,524	791	0	163	0	14.00
15.00	01500	PHARMACY	12,779	2,151	0	443	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,685	3,876	0	799	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	60,664	50,459	4,957	10,395	72,108	30.00
31.00	03100	INTENSIVE CARE UNIT	9,132	3,824	671	788	4,418	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	45,974	19,167	409	3,949	0	50.00
50.01	05001	GI LAB	10,801	6,183	1,277	1,274	0	50.01
50.02	05002	AMBULATORY CARE UNIT	9,417	8,035	768	1,655	0	50.02
51.00	05100	RECOVERY ROOM	3,141	1,478	464	305	0	51.00
53.00	05300	ANESTHESIOLOGY	805	763	0	157	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,871	15,503	1,938	3,194	0	54.00
60.00	06000	LABORATORY	25,496	7,852	0	1,618	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,471	7,527	7	1,551	0	65.00
66.00	06600	PHYSICAL THERAPY	16,162	10,054	479	2,072	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,946	581	0	120	0	69.00
69.01	06901	CATH LAB	6,172	551	154	114	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,395	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	509	273	0	56	0	74.00
76.00	03950	DIABETIC EDUCATION	360	373	0	77	0	76.00
76.01	03480	CANCER CENTER	44,241	7,350	0	1,514	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	6,604	0	0	0	0	90.00
91.00	09100	EMERGENCY	26,916	12,140	3,400	2,501	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	11,309	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	407,570	184,874	14,524	36,725	76,526	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17	703	0	145	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4	170	0	35	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	70	0	0	0	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPIRE CARE	39	0	0	0	0	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	407,700	185,747	14,524	36,905	76,526	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	59,131					11.00
13.00	01300	NURSING ADMINISTRATION	897	24,193				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	382	0	21,682			14.00
15.00	01500	PHARMACY	1,760	0	383	137,516		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,023	0	0	0	40,262	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,288	16,750	4,424	167	2,599	30.00
31.00	03100	INTENSIVE CARE UNIT	1,875	1,915	1,153	36	351	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,859	0	1,434	9,264	5,607	50.00
50.01	05001	GI LAB	1,636	0	2,652	38	2,369	50.01
50.02	05002	AMBULATORY CARE UNIT	2,075	0	1,026	83	156	50.02
51.00	05100	RECOVERY ROOM	657	0	42	31	224	51.00
53.00	05300	ANESTHESIOLOGY	0	0	704	267	653	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,963	0	1,743	136	7,554	54.00
60.00	06000	LABORATORY	2,927	0	980	62	4,533	60.00
65.00	06500	RESPIRATORY THERAPY	1,648	0	773	137	1,113	65.00
66.00	06600	PHYSICAL THERAPY	4,371	0	291	36	1,530	66.00
69.00	06900	ELECTROCARDIOLOGY	336	0	13	0	887	69.00
69.01	06901	CATH LAB	771	0	13	24	857	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	50,650	4,597	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	23	74.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	6	76.00
76.01	03480	CANCER CENTER	1,826	0	719	74,255	2,698	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	11	0	1,732	331	544	90.00
91.00	09100	EMERGENCY	5,571	5,528	3,302	106	3,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,206	0	298	1,893	552	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,082	24,193	21,682	137,516	40,262	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	35	0	0	0	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPIRE CARE	14	0	0	0	0	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	59,131	24,193	21,682	137,516	40,262	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	722,984	0	722,984	30.00
31.00	03100	INTENSIVE CARE UNIT	66,100	0	66,100	31.00
43.00	04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	478,537	0	478,537	50.00
50.01	05001	GI LAB	151,933	0	151,933	50.01
50.02	05002	AMBULATORY CARE UNIT	82,115	0	82,115	50.02
51.00	05100	RECOVERY ROOM	26,793	0	26,793	51.00
53.00	05300	ANESTHESIOLOGY	44,861	0	44,861	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	650,906	0	650,906	54.00
60.00	06000	LABORATORY	390,683	0	390,683	60.00
65.00	06500	RESPIRATORY THERAPY	145,724	0	145,724	65.00
66.00	06600	PHYSICAL THERAPY	183,609	0	183,609	66.00
69.00	06900	ELECTROCARDIOLOGY	54,208	0	54,208	69.00
69.01	06901	CATH LAB	86,444	0	86,444	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	75,642	0	75,642	73.00
74.00	07400	RENAL DIALYSIS	2,197	0	2,197	74.00
76.00	03950	DIABETIC EDUCATION	2,821	0	2,821	76.00
76.01	03480	CANCER CENTER	333,687	0	333,687	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	19,266	0	19,266	90.00
91.00	09100	EMERGENCY	323,714	0	323,714	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	35,615	0	35,615	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,877,839	0	3,877,839	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,306	0	4,306	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,041	0	1,041	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	107	0	107	192.03
192.04	19204	SMART STEPS	0	0	0	192.04
192.05	19205	RESPIRE CARE	54	0	54	192.05
193.00	19300	NONPAID WORKERS	0	0	0	193.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,883,347	0	3,883,347	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0160

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

Worksheet B-1

Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	301,311				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,528,135			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,876	0	35,936,889		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	63,548	121,311	2,433,851	-16,846,278	5.00
7.00	00700	OPERATION OF PLANT	33,701	14,583	316,758	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,258	0	0	0	8.00
9.00	00900	HOUSEKEEPING	4,954	537	1,050	0	9.00
10.00	01000	DIETARY	11,151	8,858	0	0	10.00
11.00	01100	CAFETERIA	9,517	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	360	16,210	658,077	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	861	13,926	96,176	0	14.00
15.00	01500	PHARMACY	2,341	109,219	1,072,660	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,219	559	1,463,401	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	54,927	232,658	10,528,385	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,162	22,930	1,225,485	0	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,863	294,507	2,260,824	0	50.00
50.01	05001	GI LAB	6,730	95,212	939,799	0	50.01
50.02	05002	AMBULATORY CARE UNIT	8,746	19,257	1,300,892	0	50.02
51.00	05100	RECOVERY ROOM	1,609	13,100	483,987	0	51.00
53.00	05300	ANESTHESIOLOGY	830	37,779	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,875	513,565	2,290,017	0	54.00
60.00	06000	LABORATORY	8,547	308,465	1,311,115	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,193	89,458	805,721	0	65.00
66.00	06600	PHYSICAL THERAPY	10,944	98,821	2,425,027	0	66.00
69.00	06900	ELECTROCARDIOLOGY	632	47,429	224,969	0	69.00
69.01	06901	CATH LAB	600	74,968	515,271	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
74.00	07400	RENAL DIALYSIS	297	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION	406	179	0	0	76.00
76.01	03480	CANCER CENTER	8,000	164,773	1,401,145	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	10,043	5,488	0	90.00
91.00	09100	EMERGENCY	13,214	200,673	3,129,004	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	19,115	1,031,742	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	300,361	2,528,135	35,920,844	-16,846,278	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	765	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	185	0	0	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	0	0	10,030	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	192.04
192.05	19205	RESPIRE CARE	0	0	6,015	0	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,355,210	2,528,137	8,808,352	16,846,278	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.497712	1.000001	0.245106	0.202439	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			8,438	407,700	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000235	0.004899	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: 14-0160

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

Worksheet B-1

Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	202,186				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,258	561,502			8.00
9.00	00900	HOUSEKEEPING	4,954	0	194,974		9.00
10.00	01000	DIETARY	11,151	0	11,151	60,995	10.00
11.00	01100	CAFETERIA	9,517	0	9,517	0	11.00
13.00	01300	NURSING ADMINISTRATION	360	0	360	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	861	0	861	0	14.00
15.00	01500	PHARMACY	2,341	0	2,341	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,219	0	4,219	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	54,927	191,575	54,927	57,474	30.00
31.00	03100	INTENSIVE CARE UNIT	4,162	25,935	4,162	3,521	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,863	15,813	20,863	0	50.00
50.01	05001	GI LAB	6,730	49,368	6,730	0	50.01
50.02	05002	AMBULATORY CARE UNIT	8,746	29,707	8,746	0	50.02
51.00	05100	RECOVERY ROOM	1,609	17,952	1,609	0	51.00
53.00	05300	ANESTHESIOLOGY	830	0	830	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,875	74,939	16,875	0	54.00
60.00	06000	LABORATORY	8,547	0	8,547	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,193	279	8,193	0	65.00
66.00	06600	PHYSICAL THERAPY	10,944	18,533	10,944	0	66.00
69.00	06900	ELECTROCARDIOLOGY	632	0	632	0	69.00
69.01	06901	CATH LAB	600	5,936	600	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
74.00	07400	RENAL DIALYSIS	297	0	297	0	74.00
76.00	03950	DIABETIC EDUCATION	406	0	406	0	76.00
76.01	03480	CANCER CENTER	8,000	0	8,000	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	13,214	131,465	13,214	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	201,236	561,502	194,024	60,995	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	765	0	765	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	185	0	185	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	0	0	0	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	192.04
192.05	19205	RESPIRE CARE	0	0	0	0	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,789,405	616,621	2,457,790	1,670,899	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.688114	1.098163	12.605732	27.394032	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	185,747	14,524	36,905	76,526	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.918694	0.025866	0.189282	1.254627	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: 14-0160

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

Worksheet B-1

Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Description		NURSING ADMINISTRATIO N (DIRECT)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
		13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION	415,762			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,337,683		14.00
15.00	01500	PHARMACY	0	41,263	11,078,249	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	498,427,169	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	287,849	476,885	13,428	30.00
31.00	03100	INTENSIVE CARE UNIT	32,911	124,366	2,886	31.00
43.00	04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	154,654	746,339	50.00
50.01	05001	GI LAB	0	285,889	3,071	50.01
50.02	05002	AMBULATORY CARE UNIT	0	110,662	6,663	50.02
51.00	05100	RECOVERY ROOM	0	4,527	2,493	51.00
53.00	05300	ANESTHESIOLOGY	0	75,854	21,492	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	187,958	10,922	54.00
60.00	06000	LABORATORY	0	105,707	4,993	60.00
65.00	06500	RESPIRATORY THERAPY	0	83,323	11,052	65.00
66.00	06600	PHYSICAL THERAPY	0	31,356	2,879	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,363	0	69.00
69.01	06901	CATH LAB	0	1,449	1,927	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	4,080,370	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION	0	5	0	76.00
76.01	03480	CANCER CENTER	0	77,555	5,981,976	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	186,745	26,653	90.00
91.00	09100	EMERGENCY	95,002	356,033	8,572	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	32,089	152,533	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	415,762	2,337,683	11,078,249	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	0	0	0	192.03
192.04	19204	SMART STEPS	0	0	0	192.04
192.05	19205	RESPIRE CARE	0	0	0	192.05
193.00	19300	NONPAID WORKERS	0	0	0	193.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,245,670	662,220	3,285,759	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.996113	0.283280	0.296596	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	24,193	21,682	137,516	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.058190	0.009275	0.012413	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: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/25/2020 9:08 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	20,425,432		20,425,432	0	20,425,432	30.00	
31.00	03100	INTENSIVE CARE UNIT	2,737,257		2,737,257	0	2,737,257	31.00	
43.00	04300	NURSERY	0		0	0	0	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	12,905,259		12,905,259	0	12,905,259	50.00	
50.01	05001	GI LAB	3,277,326		3,277,326	0	3,277,326	50.01	
50.02	05002	AMBULATORY CARE UNIT	2,769,612		2,769,612	0	2,769,612	50.02	
51.00	05100	RECOVERY ROOM	889,233		889,233	0	889,233	51.00	
53.00	05300	ANESTHESIOLOGY	309,879		309,879	0	309,879	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,886,420		7,886,420	0	7,886,420	54.00	
60.00	06000	LABORATORY	7,063,726		7,063,726	0	7,063,726	60.00	
65.00	06500	RESPIRATORY THERAPY	2,054,443	0	2,054,443	0	2,054,443	65.00	
66.00	06600	PHYSICAL THERAPY	4,651,984	0	4,651,984	0	4,651,984	66.00	
69.00	06900	ELECTROCARDIOLOGY	584,708		584,708	0	584,708	69.00	
69.01	06901	CATH LAB	1,638,567		1,638,567	0	1,638,567	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	6,598,298		6,598,298	0	6,598,298	73.00	
74.00	07400	RENAL DIALYSIS	137,545		137,545	0	137,545	74.00	
76.00	03950	DIABETIC EDUCATION	103,624		103,624	0	103,624	76.00	
76.01	03480	CANCER CENTER	13,224,143		13,224,143	0	13,224,143	76.01	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	1,727,362		1,727,362	0	1,727,362	90.00	
91.00	09100	EMERGENCY	8,068,213		8,068,213	0	8,068,213	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,581,649		5,581,649		5,581,649	92.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
116.00	11600	HOSPICE	2,941,939		2,941,939		2,941,939	116.00	
200.00		Subtotal (see instructions)	105,576,619	0	105,576,619	0	105,576,619	200.00	
201.00		Less Observation Beds	5,581,649		5,581,649		5,581,649	201.00	
202.00		Total (see instructions)	99,994,970	0	99,994,970	0	99,994,970	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/25/2020 9:08 am

			Title XVIII		Hospital	PPS		
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	24,918,306		24,918,306			30.00
31.00	03100	INTENSIVE CARE UNIT	4,332,343		4,332,343			31.00
43.00	04300	NURSERY	0		0			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	29,548,827	39,675,790	69,224,617	0.186426	0.000000	50.00
50.01	05001	GI LAB	4,672,668	24,576,448	29,249,116	0.112049	0.000000	50.01
50.02	05002	AMBULATORY CARE UNIT	440,520	1,487,233	1,927,753	1.436705	0.000000	50.02
51.00	05100	RECOVERY ROOM	1,026,742	1,733,862	2,760,604	0.322115	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	2,672,513	5,389,788	8,062,301	0.038436	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,834,903	78,775,349	94,610,252	0.083357	0.000000	54.00
60.00	06000	LABORATORY	12,923,213	43,042,180	55,965,393	0.126216	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	9,847,929	3,888,387	13,736,316	0.149563	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,521,390	15,373,452	18,894,842	0.246204	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	3,158,846	7,789,386	10,948,232	0.053407	0.000000	69.00
69.01	06901	CATH LAB	4,388,865	6,193,784	10,582,649	0.154835	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,026,824	31,731,635	56,758,459	0.116252	0.000000	73.00
74.00	07400	RENAL DIALYSIS	211,968	69,552	281,520	0.488580	0.000000	74.00
76.00	03950	DIABETIC EDUCATION	0	74,984	74,984	1.381948	0.000000	76.00
76.01	03480	CANCER CENTER	24,298	33,290,303	33,314,601	0.396947	0.000000	76.01
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	10,652	6,711,557	6,722,209	0.256963	0.000000	90.00
91.00	09100	EMERGENCY	7,652,458	34,431,605	42,084,063	0.191717	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,291,571	5,870,852	7,162,423	0.779296	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,922	6,814,264	6,816,186			116.00
200.00		Subtotal (see instructions)	151,506,758	346,920,411	498,427,169			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	151,506,758	346,920,411	498,427,169			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.186426			50.00
50.01	05001	GI LAB	0.112049			50.01
50.02	05002	AMBULATORY CARE UNIT	1.436705			50.02
51.00	05100	RECOVERY ROOM	0.322115			51.00
53.00	05300	ANESTHESIOLOGY	0.038436			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.083357			54.00
60.00	06000	LABORATORY	0.126216			60.00
65.00	06500	RESPIRATORY THERAPY	0.149563			65.00
66.00	06600	PHYSICAL THERAPY	0.246204			66.00
69.00	06900	ELECTROCARDIOLOGY	0.053407			69.00
69.01	06901	CATH LAB	0.154835			69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.116252			73.00
74.00	07400	RENAL DIALYSIS	0.488580			74.00
76.00	03950	DIABETIC EDUCATION	1.381948			76.00
76.01	03480	CANCER CENTER	0.396947			76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.256963			90.00
91.00	09100	EMERGENCY	0.191717			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.779296			92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
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: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/25/2020 9:08 am

			Title XIX	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	20,425,432		20,425,432	30.00
31.00	03100	INTENSIVE CARE UNIT	2,737,257		2,737,257	31.00
43.00	04300	NURSERY	0		0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,905,259		12,905,259	50.00
50.01	05001	GI LAB	3,277,326		3,277,326	50.01
50.02	05002	AMBULATORY CARE UNIT	2,769,612		2,769,612	50.02
51.00	05100	RECOVERY ROOM	889,233		889,233	51.00
53.00	05300	ANESTHESIOLOGY	309,879		309,879	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,886,420		7,886,420	54.00
60.00	06000	LABORATORY	7,063,726		7,063,726	60.00
65.00	06500	RESPIRATORY THERAPY	2,054,443	0	2,054,443	65.00
66.00	06600	PHYSICAL THERAPY	4,651,984	0	4,651,984	66.00
69.00	06900	ELECTROCARDIOLOGY	584,708		584,708	69.00
69.01	06901	CATH LAB	1,638,567		1,638,567	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,598,298		6,598,298	73.00
74.00	07400	RENAL DIALYSIS	137,545		137,545	74.00
76.00	03950	DIABETIC EDUCATION	103,624		103,624	76.00
76.01	03480	CANCER CENTER	13,224,143		13,224,143	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,727,362		1,727,362	90.00
91.00	09100	EMERGENCY	8,068,213		8,068,213	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,581,649		5,581,649	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	2,941,939		2,941,939	116.00
200.00		Subtotal (see instructions)	105,576,619	0	105,576,619	200.00
201.00		Less Observation Beds	5,581,649		5,581,649	201.00
202.00		Total (see instructions)	99,994,970	0	99,994,970	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/25/2020 9:08 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	24,918,306		24,918,306			30.00
31.00	03100	INTENSIVE CARE UNIT	4,332,343		4,332,343			31.00
43.00	04300	NURSERY	0		0			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	29,548,827	39,675,790	69,224,617	0.186426	0.000000	50.00
50.01	05001	GI LAB	4,672,668	24,576,448	29,249,116	0.112049	0.000000	50.01
50.02	05002	AMBULATORY CARE UNIT	440,520	1,487,233	1,927,753	1.436705	0.000000	50.02
51.00	05100	RECOVERY ROOM	1,026,742	1,733,862	2,760,604	0.322115	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	2,672,513	5,389,788	8,062,301	0.038436	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,834,903	78,775,349	94,610,252	0.083357	0.000000	54.00
60.00	06000	LABORATORY	12,923,213	43,042,180	55,965,393	0.126216	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	9,847,929	3,888,387	13,736,316	0.149563	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,521,390	15,373,452	18,894,842	0.246204	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	3,158,846	7,789,386	10,948,232	0.053407	0.000000	69.00
69.01	06901	CATH LAB	4,388,865	6,193,784	10,582,649	0.154835	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,026,824	31,731,635	56,758,459	0.116252	0.000000	73.00
74.00	07400	RENAL DIALYSIS	211,968	69,552	281,520	0.488580	0.000000	74.00
76.00	03950	DIABETIC EDUCATION	0	74,984	74,984	1.381948	0.000000	76.00
76.01	03480	CANCER CENTER	24,298	33,290,303	33,314,601	0.396947	0.000000	76.01
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	10,652	6,711,557	6,722,209	0.256963	0.000000	90.00
91.00	09100	EMERGENCY	7,652,458	34,431,605	42,084,063	0.191717	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,291,571	5,870,852	7,162,423	0.779296	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,922	6,814,264	6,816,186			116.00
200.00		Subtotal (see instructions)	151,506,758	346,920,411	498,427,169			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	151,506,758	346,920,411	498,427,169			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/25/2020 9:08 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
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
50.01	05001	GI LAB	0.000000		50.01
50.02	05002	AMBULATORY CARE UNIT	0.000000		50.02
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CATH LAB	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03950	DIABETIC EDUCATION	0.000000		76.00
76.01	03480	CANCER CENTER	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS					
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
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
8/25/2020 9:08 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	722,984	0	722,984	17,126	42.22	30.00
31.00	INTENSIVE CARE UNIT	66,100		66,100	1,328	49.77	31.00
43.00	NURSERY	0		0	622	0.00	43.00
200.00	Total (lines 30 through 199)	789,084		789,084	19,076		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,555	234,532				30.00
31.00	INTENSIVE CARE UNIT	504	25,084				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	6,059	259,616				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0160	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 8/25/2020 9:08 am			
				Title XVIII		Hospital		PPS	
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	478,537	69,224,617	0.006913	10,704,682	74,001	50.00	
50.01	05001	GI LAB	151,933	29,249,116	0.005194	2,219,775	11,530	50.01	
50.02	05002	AMBULATORY CARE UNIT	82,115	1,927,753	0.042596	440,497	18,763	50.02	
51.00	05100	RECOVERY ROOM	26,793	2,760,604	0.009705	335,487	3,256	51.00	
53.00	05300	ANESTHESIOLOGY	44,861	8,062,301	0.005564	909,442	5,060	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	650,906	94,610,252	0.006880	6,460,174	44,446	54.00	
60.00	06000	LABORATORY	390,683	55,965,393	0.006981	5,518,683	38,526	60.00	
65.00	06500	RESPIRATORY THERAPY	145,724	13,736,316	0.010609	4,731,653	50,198	65.00	
66.00	06600	PHYSICAL THERAPY	183,609	18,894,842	0.009717	1,545,916	15,022	66.00	
69.00	06900	ELECTROCARDIOLOGY	54,208	10,948,232	0.004951	1,420,127	7,031	69.00	
69.01	06901	CATH LAB	86,444	10,582,649	0.008168	1,728,051	14,115	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	75,642	56,758,459	0.001333	10,120,296	13,490	73.00	
74.00	07400	RENAL DIALYSIS	2,197	281,520	0.007804	5,040	39	74.00	
76.00	03950	DIABETIC EDUCATION	2,821	74,984	0.037621	0	0	76.00	
76.01	03480	CANCER CENTER	333,687	33,314,601	0.010016	0	0	76.01	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	19,266	6,722,209	0.002866	3,866	11	90.00	
91.00	09100	EMERGENCY	323,714	42,084,063	0.007692	3,357,239	25,824	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	197,568	7,162,423	0.027584	564,544	15,572	92.00	
200.00		Total (lines 50 through 199)	3,250,708	462,360,334		50,065,472	336,884	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN:14-0160		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 8/25/2020 9:08 am	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00		
43.00	04300	NURSERY	0	0	0	0	0	43.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	17,126	0.00	5,555	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	1,328	0.00	504	31.00		
43.00	04300	NURSERY		0	622	0.00	0	43.00		
200.00		Total (lines 30 through 199)		0	19,076		6,059	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
31.00	03100	INTENSIVE CARE UNIT	0						31.00	
43.00	04300	NURSERY	0						43.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
50.01	05001	GI LAB	0	0	0	0	0	50.01
50.02	05002	AMBULATORY CARE UNIT	0	0	0	0	0	50.02
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CATH LAB	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.01	03480	CANCER CENTER	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0160

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

Worksheet D
Part IV
Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Description		Title XVIII		Hospital		PPS	
		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	69,224,617	0.000000 50.00
50.01	05001	GI LAB	0	0	0	29,249,116	0.000000 50.01
50.02	05002	AMBULATORY CARE UNIT	0	0	0	1,927,753	0.000000 50.02
51.00	05100	RECOVERY ROOM	0	0	0	2,760,604	0.000000 51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	8,062,301	0.000000 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	94,610,252	0.000000 54.00
60.00	06000	LABORATORY	0	0	0	55,965,393	0.000000 60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,736,316	0.000000 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	18,894,842	0.000000 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10,948,232	0.000000 69.00
69.01	06901	CATH LAB	0	0	0	10,582,649	0.000000 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	56,758,459	0.000000 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	281,520	0.000000 74.00
76.00	03950	DIABETIC EDUCATION	0	0	0	74,984	0.000000 76.00
76.01	03480	CANCER CENTER	0	0	0	33,314,601	0.000000 76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	6,722,209	0.000000 90.00
91.00	09100	EMERGENCY	0	0	0	42,084,063	0.000000 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,162,423	0.000000 92.00
200.00		Total (lines 50 through 199)	0	0	0	462,360,334	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Description			Title XVIII		Hospital	PPS	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	10,704,682	0	8,937,940	0
50.01	05001	GI LAB	0.000000	2,219,775	0	7,632,086	0
50.02	05002	AMBULATORY CARE UNIT	0.000000	440,497	0	559,214	0
51.00	05100	RECOVERY ROOM	0.000000	335,487	0	339,900	0
53.00	05300	ANESTHESIOLOGY	0.000000	909,442	0	1,300,431	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	6,460,174	0	21,019,660	0
60.00	06000	LABORATORY	0.000000	5,518,683	0	5,058,699	0
65.00	06500	RESPIRATORY THERAPY	0.000000	4,731,653	0	1,073,426	0
66.00	06600	PHYSICAL THERAPY	0.000000	1,545,916	0	1,239,540	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,420,127	0	2,641,417	0
69.01	06901	CATH LAB	0.000000	1,728,051	0	2,333,891	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	10,120,296	0	10,546,542	0
74.00	07400	RENAL DIALYSIS	0.000000	5,040	0	33,996	0
76.00	03950	DIABETIC EDUCATION	0.000000	0	0	0	0
76.01	03480	CANCER CENTER	0.000000	0	0	12,060,224	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	3,866	0	3,564,553	0
91.00	09100	EMERGENCY	0.000000	3,357,239	0	6,653,014	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	564,544	0	2,124,531	0
200.00		Total (lines 50 through 199)		50,065,472	0	87,119,064	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/25/2020 9:08 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.186426	8,937,940	0	4,091	1,666,264	50.00
50.01	05001	GI LAB	0.112049	7,632,086	0	0	855,168	50.01
50.02	05002	AMBULATORY CARE UNIT	1.436705	559,214	0	0	803,426	50.02
51.00	05100	RECOVERY ROOM	0.322115	339,900	0	0	109,487	51.00
53.00	05300	ANESTHESIOLOGY	0.038436	1,300,431	0	0	49,983	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.083357	21,019,660	0	1,371	1,752,136	54.00
60.00	06000	LABORATORY	0.126216	5,058,699	0	0	638,489	60.00
65.00	06500	RESPIRATORY THERAPY	0.149563	1,073,426	0	0	160,545	65.00
66.00	06600	PHYSICAL THERAPY	0.246204	1,239,540	0	0	305,180	66.00
69.00	06900	ELECTROCARDIOLOGY	0.053407	2,641,417	0	0	141,070	69.00
69.01	06901	CATH LAB	0.154835	2,333,891	0	0	361,368	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.116252	10,546,542	0	32,988	1,226,057	73.00
74.00	07400	RENAL DIALYSIS	0.488580	33,996	0	0	16,610	74.00
76.00	03950	DIABETIC EDUCATION	1.381948	0	0	0	0	76.00
76.01	03480	CANCER CENTER	0.396947	12,060,224	0	27,524	4,787,270	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.256963	3,564,553	0	2,481	915,958	90.00
91.00	09100	EMERGENCY	0.191717	6,653,014	0	0	1,275,496	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.779296	2,124,531	0	0	1,655,639	92.00
200.00		Subtotal (see instructions)		87,119,064	0	68,455	16,720,146	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		87,119,064	0	68,455	16,720,146	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0160		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 8/25/2020 9:08 am	
				Title XVIII		Hospital		PPS	
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	763					
50.01	05001	GI LAB	0	0					
50.02	05002	AMBULATORY CARE UNIT	0	0					
51.00	05100	RECOVERY ROOM	0	0					
53.00	05300	ANESTHESIOLOGY	0	0					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	114					
60.00	06000	LABORATORY	0	0					
65.00	06500	RESPIRATORY THERAPY	0	0					
66.00	06600	PHYSICAL THERAPY	0	0					
69.00	06900	ELECTROCARDIOLOGY	0	0					
69.01	06901	CATH LAB	0	0					
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,835					
74.00	07400	RENAL DIALYSIS	0	0					
76.00	03950	DIABETIC EDUCATION	0	0					
76.01	03480	CANCER CENTER	0	10,926					
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	638					
91.00	09100	EMERGENCY	0	0					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					
200.00		Subtotal (see instructions)	0	16,276					
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						
202.00		Net Charges (line 200 - line 201)	0	16,276					

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0160	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/25/2020 9:08 am	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			17,126	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			17,126	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			12,446	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			5,555	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			20,425,432	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			20,425,432	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)			20,425,432	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,192.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			6,625,226	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)			6,625,226	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0160

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

Worksheet D-1

Date/Time Prepared:
8/25/2020 9:08 am

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,737,257	1,328	2,061.19	504	1,038,840
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					7,950,532
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					15,614,598
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					259,616
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					336,884
52.00	Total Program excludable cost (sum of lines 50 and 51)					596,500
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					15,018,098
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
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)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00	Program routine service cost (line 9 x line 71)					
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00	Per diem capital-related costs (line 75 ÷ line 2)					
77.00	Program capital-related costs (line 9 x line 76)					
78.00	Inpatient routine service cost (line 74 minus line 77)					
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00	Inpatient routine service cost per diem limitation					
82.00	Inpatient routine service cost limitation (line 9 x line 81)					
83.00	Reasonable inpatient routine service costs (see instructions)					
84.00	Program inpatient ancillary services (see instructions)					
85.00	Utilization review - physician compensation (see instructions)					
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					4,680
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,192.66
89.00	Observation bed cost (line 87 x line 88) (see instructions)					5,581,649

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-0160		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 8/25/2020 9:08 am		
				Title XVIII		Hospital		PPS		
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	722,984	20,425,432	0.035396	5,581,649	197,568		90.00		
91.00	Nursing School cost	0	20,425,432	0.000000	5,581,649	0		91.00		
92.00	Allied health cost	0	20,425,432	0.000000	5,581,649	0		92.00		
93.00	All other Medical Education	0	20,425,432	0.000000	5,581,649	0		93.00		

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0160	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/25/2020 9:08 am	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		8,464,500		30.00
31.00	03100	INTENSIVE CARE UNIT		1,910,334		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.186426	10,704,682	1,995,631	50.00
50.01	05001	GI LAB	0.112049	2,219,775	248,724	50.01
50.02	05002	AMBULATORY CARE UNIT	1.436705	440,497	632,864	50.02
51.00	05100	RECOVERY ROOM	0.322115	335,487	108,065	51.00
53.00	05300	ANESTHESIOLOGY	0.038436	909,442	34,955	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.083357	6,460,174	538,501	54.00
60.00	06000	LABORATORY	0.126216	5,518,683	696,546	60.00
65.00	06500	RESPIRATORY THERAPY	0.149563	4,731,653	707,680	65.00
66.00	06600	PHYSICAL THERAPY	0.246204	1,545,916	380,611	66.00
69.00	06900	ELECTROCARDIOLOGY	0.053407	1,420,127	75,845	69.00
69.01	06901	CATH LAB	0.154835	1,728,051	267,563	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.116252	10,120,296	1,176,505	73.00
74.00	07400	RENAL DIALYSIS	0.488580	5,040	2,462	74.00
76.00	03950	DIABETIC EDUCATION	1.381948	0	0	76.00
76.01	03480	CANCER CENTER	0.396947	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.256963	3,866	993	90.00
91.00	09100	EMERGENCY	0.191717	3,357,239	643,640	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.779296	564,544	439,947	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		50,065,472	7,950,532	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)		50,065,472		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0160	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/25/2020 9:08 am
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		11,007,420	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		406,020	2.04
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		87.18	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.37	30.00
31.00	Percentage of Medicaid patient days (see instructions)		18.17	31.00
32.00	Sum of lines 30 and 31		21.54	32.00
33.00	Allowable disproportionate share percentage (see instructions)		6.99	33.00
34.00	Disproportionate share adjustment (see instructions)		192,355	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0160	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/25/2020 9:08 am
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	846,086	722,316	
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	632,826	181,566	
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	814,392		
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	
47.00	Subtotal (see instructions)	12,420,187		
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions))	12,570,933		
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		12,533,247	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		893,239	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	
53.00	Nursing and Allied Health Managed Care payment		0	
54.00	Special add-on payments for new technologies		0	
54.01	Islet isolation add-on payment		0	
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	
59.00	Total (sum of amounts on lines 49 through 58)		13,426,486	
60.00	Primary payer payments		3,636	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		13,422,850	
62.00	Deductibles billed to program beneficiaries		1,370,532	
63.00	Coinurance billed to program beneficiaries		30,008	
64.00	Allowable bad debts (see instructions)		555,862	
65.00	Adjusted reimbursable bad debts (see instructions)		361,310	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		441,770	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		12,383,620	
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	
70.87	Demonstration payment adjustment amount before sequestration		0	
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		381	
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-1,189	
70.92	Bundled Model 1 discount amount (see instructions)		0	
70.93	HVBP payment adjustment amount (see instructions)		36,563	
70.94	HRR adjustment amount (see instructions)		-114,218	
70.95	Recovery of accelerated depreciation		0	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0160	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/25/2020 9:08 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		12,305,157	71.00	
71.01	Sequestration adjustment (see instructions)		246,103	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
71.03	Sequestration adjustment-PARHM pass-throughs			71.03	
72.00	Interim payments		12,233,850	72.00	
72.01	Interim payments-PARHM			72.01	
73.00	Tentative settlement (for contractor use only)		0	73.00	
73.01	Tentative settlement-PARHM (for contractor use only)			73.01	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-174,796	74.00	
74.01	Balance due provider/program-PARHM (see instructions)			74.01	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		77,052	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		84,563	28,497	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		1.0026120626	1.0056279287	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		221	160	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.9916	0.9832	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-710	-479	104.00
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 inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/25/2020 9:08 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	11,007,420	0		11,007,420	11,007,420
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	361,942		361,942
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	406,020	0		406,020	406,020
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0699	0.0699	0.0699	0.0699	
11.00	Disproportionate share adjustment (see instructions)	34.00	192,355	0	0	192,355	192,355
11.01	Uncompensated care payments	36.00	814,392	237,096	0	0	237,096
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	12,420,187	237,096	361,942	11,821,149	12,420,187
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	12,570,933	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	12,533,247	237,096	361,942	11,934,209	12,533,247

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/25/2020 9:08 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	893,239	0	0	893,239	893,239	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			237,096	361,942	12,827,448	13,426,486	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	889,005	0	0	889,005	889,005	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	4,234	0	0	4,234	4,234	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	893,239	0	0	893,239	893,239	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000227	0.000227		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			82		82	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				2,912	2,912	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/25/2020 9:08 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	11,007,420		11,007,420	11,007,420	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	361,942		361,942	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	406,020		406,020	406,020	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0699	0.0699	0.0699		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	192,355	0	192,355	192,355	11.00
11.01	Uncompensated care payments	36.00	814,392	525,360	213,260	738,620	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	12,420,187	887,302	11,532,885	12,420,187	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	12,570,933	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	12,533,247	887,302	11,645,945	12,533,247	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	893,239	0	893,239	893,239	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			887,302	12,539,184	13,426,486	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
8/25/2020 9:08 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	889,005	0	889,005	889,005	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	4,234	0	4,234	4,234	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	893,239	0	893,239	893,239	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	36,563	0	36,563	36,563	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	381	221	160	381	30.01
31.00	HRR adjustment (see instructions)	70.94	-114,218	0	-114,218	-114,218	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-1,189	-710	-479	-1,189	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0160	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/25/2020 9:08 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		16,276	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		16,720,146	2.00
3.00	OPPS payments		13,999,942	3.00
4.00	Outlier payment (see instructions)		103,090	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.822	5.00
6.00	Line 2 times line 5		13,743,960	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)		16,276	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		68,455	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)		68,455	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)		68,455	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		52,179	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)		16,276	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)		14,103,032	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,766,303	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)		11,353,005	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)		11,353,005	30.00
31.00	Primary payer payments		622	31.00
32.00	Subtotal (line 30 minus line 31)		11,352,383	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)		877,103	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		570,117	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		751,269	36.00
37.00	Subtotal (see instructions)		11,922,500	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)		11,922,500	40.00
40.01	Sequestration adjustment (see instructions)		238,450	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		11,669,753	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)		14,297	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: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
8/25/2020 9:08 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		12,284,291		11,456,081	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	08/12/2019	213,672	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	08/12/2019	50,441		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)		-50,441		213,672	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)		12,233,850		11,669,753	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		14,297	6.01
6.02	SETTLEMENT TO PROGRAM		174,796		0	6.02
7.00	Total Medicare program liability (see instructions)		12,059,054		11,684,050	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: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part II
Date/Time Prepared:
8/25/2020 9:08 am

Title XVIII

Hospital

PPS

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

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

Provider CCN: 14-0160

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

Worksheet G

Date/Time Prepared:
8/25/2020 9:08 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	32,135,874	0	0	0	1.00
2.00	Temporary investments	8,445,942	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	23,299,500	0	0	0	4.00
5.00	Other receivable	1,632,249	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	5,427,293	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)	70,940,858	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	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	20,570,989	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	20,570,989	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	6,257,771	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	2,315,194	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,572,965	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	100,084,812	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	6,248,174	0	0	0	37.00
38.00	Salaries, wages, and fees payable	9,414,849	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	6,387,229	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	22,050,252	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	5,085,608	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5,085,608	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	27,135,860	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	72,948,952				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	72,948,952	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	100,084,812	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0160

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

Worksheet G-1

Date/Time Prepared:
8/25/2020 9:08 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		73,638,065		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-892,901				2.00
3.00	Total (sum of line 1 and line 2)		72,745,164		0		3.00
4.00	PRIOR PERIOD ADJ	203,788		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)		203,788		0		10.00
11.00	Subtotal (line 3 plus line 10)		72,948,952		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		72,948,952		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	PRIOR PERIOD ADJ		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0160

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	38,323,260		38,323,260	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				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)	38,323,260		38,323,260	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	4,332,343		4,332,343	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	4,332,343		4,332,343	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	42,655,603		42,655,603	17.00
18.00	Ancillary services	116,499,815	310,642,666	427,142,481	18.00
19.00	Outpatient services	10,459,561	57,122,562	67,582,123	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	1,922	6,814,264	6,816,186	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)	169,616,901	374,579,492	544,196,393	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		121,752,591		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		121,752,591		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0160

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

Worksheet G-3

Date/Time Prepared:
8/25/2020 9:08 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	544,196,393	1.00
2.00	Less contractual allowances and discounts on patients' accounts	430,888,586	2.00
3.00	Net patient revenues (line 1 minus line 2)	113,307,807	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	121,752,591	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-8,444,784	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	26,477	6.00
7.00	Income from investments	1,324,633	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	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	6,387,033	24.00
24.01	MEDICAID ASSESSMENT REV	148,227	24.01
24.02	SALE OF ASSETS	9,949	24.02
24.03	OTHER (SPECIFY)	0	24.03
24.04	NET ASSETS RELEASED	325,432	24.04
24.05	OTHER (SPECIFY)	0	24.05
24.06	OTHER (SPECIFY)	0	24.06
25.00	Total other income (sum of lines 6-24)	8,221,751	25.00
26.00	Total (line 5 plus line 25)	-223,033	26.00
27.00	OTHER NON-OPERATING REVENUE	216,132	27.00
27.01	TRANSFER FROM AFFIL	453,736	27.01
27.02	OTHER EXPENSES (SPECIFY)	0	27.02
27.03	OTHER EXPENSES (SPECIFY)	0	27.03
27.05	OTHER EXPENSES (SPECIFY)	0	27.05
27.06	OTHER EXPENSES (SPECIFY)	0	27.06
28.00	Total other expenses (sum of line 27 and subscripts)	669,868	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-892,901	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0160

Period:

Worksheet 0

Hospice CCN: 14-1560

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/25/2020 9:08 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI- CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	5,987	5,987	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	99,328	99,328	0	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	57	57	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	69,714	69,714	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	24,231	0	24,231	0	13.00
14.00	PHARMACY*	0	152,532	152,532	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	231,976	11,500	243,476	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	25.00
26.00	PHYSICIAN SERVICES**	12,335	0	12,335	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	27.00
28.00	REGISTERED NURSE**	497,330	630,379	1,127,709	0	28.00
29.00	LPN/LVN**	113,112	0	113,112	0	29.00
30.00	PHYSICAL THERAPY**	37	0	37	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	141,399	0	141,399	0	33.00
34.00	SPIRITUAL COUNSELING**	11,191	0	11,191	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	31,826	31,826	0	38.00
39.00	PATIENT TRANSPORTATION**	0	14,964	14,964	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	132	0	132	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	46.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	71.00
100.00	TOTAL	1,031,743	1,016,287	2,048,030	0	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0160

Period:

Worksheet 0

Hospice CCN: 14-1560

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/25/2020 9:08 am

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I	
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	5,987		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	99,328		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	57		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	69,714		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	24,231		13.00
14.00	PHARMACY*	0	152,532		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	-11,500	231,976		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
DIRECT PATIENT CARE SERVICE COST CENTERS					
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	12,335		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	1,127,709		28.00
29.00	LPN/LVN**	0	113,112		29.00
30.00	PHYSICAL THERAPY**	0	37		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	141,399		33.00
34.00	SPIRITUAL COUNSELING**	0	11,191		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	31,826		38.00
39.00	PATIENT TRANSPORTATION**	0	14,964		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	132		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	-11,500	2,036,530		100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 14-0160

Period:

Worksheet 0-2

Hospice CCN: 14-1560

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/25/2020 9:08 am

				Hospice I		07/20/2020 0:00 am	
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	12,284	0	12,284	0	12,284	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	495,281	627,782	1,123,063	0	1,123,063	28.00
29.00	LPN/LVN	112,646	0	112,646	0	112,646	29.00
30.00	PHYSICAL THERAPY	37	0	37	0	37	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	140,816	0	140,816	0	140,816	33.00
34.00	SPIRITUAL COUNSELING	11,145	0	11,145	0	11,145	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	31,695	31,695	0	31,695	38.00
39.00	PATIENT TRANSPORTATION	0	14,902	14,902	0	14,902	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	132	0	132	0	132	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	772,341	674,379	1,446,720	0	1,446,720	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	12,284	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	1,123,063	28.00
29.00	LPN/LVN	0	112,646	29.00
30.00	PHYSICAL THERAPY	0	37	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	140,816	33.00
34.00	SPIRITUAL COUNSELING	0	11,145	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	31,695	38.00
39.00	PATIENT TRANSPORTATION	0	14,902	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	132	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	1,446,720	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT
RESPIRE CARE

Provider CCN: 14-0160

Period:
From 01/01/2019

Worksheet 0-3

Hospice CCN: 14-1560

To 12/31/2019

Date/Time Prepared:
8/25/2020 9:08 am

				Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	29	0	29	0	29	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	1,157	1,466	2,623	0	2,623	28.00
29.00	LPN/LVN	263	0	263	0	263	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	329	0	329	0	329	33.00
34.00	SPIRITUAL COUNSELING	26	0	26	0	26	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	74	74	0	74	38.00
39.00	PATIENT TRANSPORTATION	0	35	35	0	35	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	1,804	1,575	3,379	0	3,379	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	29	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	2,623	28.00
29.00	LPN/LVN	0	263	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	329	33.00
34.00	SPIRITUAL COUNSELING	0	26	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	74	38.00
39.00	PATIENT TRANSPORTATION	0	35	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	3,379	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE	Provider CCN: 14-0160 Hospice CCN: 14-1560	Period: From 01/01/2019 To 12/31/2019	Worksheet 0-4 Date/Time Prepared: 8/25/2020 9:08 am
--	---	---	---

	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	Hospice I RECLASSIFI- CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00 INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00 PHYSICIAN SERVICES	22	0	22	0	22	26.00
27.00 NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00 REGISTERED NURSE	892	1,131	2,023	0	2,023	28.00
29.00 LPN/LVN	203	0	203	0	203	29.00
30.00 PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00 OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	254	0	254	0	254	33.00
34.00 SPIRITUAL COUNSELING	20	0	20	0	20	34.00
35.00 DIETARY COUNSELING	0	0	0	0	0	35.00
36.00 COUNSELING - OTHER	0	0	0	0	0	36.00
37.00 HOSPICE AIDE & HOME MAKER SERVICES	0	0	0	0	0	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	57	57	0	57	38.00
39.00 PATIENT TRANSPORTATION	0	27	27	0	27	39.00
40.00 IMAGING SERVICES	0	0	0	0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00 MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00 OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00 TOTAL *	1,391	1,215	2,606	0	2,606	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

	ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
	6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00 INPATIENT CARE-CONTRACTED	0	0	25.00
26.00 PHYSICIAN SERVICES	0	22	26.00
27.00 NURSE PRACTITIONER	0	0	27.00
28.00 REGISTERED NURSE	0	2,023	28.00
29.00 LPN/LVN	0	203	29.00
30.00 PHYSICAL THERAPY	0	0	30.00
31.00 OCCUPATIONAL THERAPY	0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	0	254	33.00
34.00 SPIRITUAL COUNSELING	0	20	34.00
35.00 DIETARY COUNSELING	0	0	35.00
36.00 COUNSELING - OTHER	0	0	36.00
37.00 HOSPICE AIDE & HOME MAKER SERVICES	0	0	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	57	38.00
39.00 PATIENT TRANSPORTATION	0	27	39.00
40.00 IMAGING SERVICES	0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0	41.00
42.00 MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50 DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00 OUTPATIENT SERVICES	0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00 TOTAL *	0	2,606	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION		Provider CCN: 14-0160 Hospice CCN: 14-1560	Period: From 01/01/2019 To 12/31/2019	Worksheet 0-5 Date/Time Prepared: 8/25/2020 9:08 am	
Descriptions		HOSPICE DIRECT EXPENSES (see instructions)	Hospice I GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	19,115	19,115	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	5,987	252,886	258,873	3.00
4.00	ADMINISTRATIVE & GENERAL	99,328	533,170	632,498	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	57	9,090	9,147	10.00
11.00	MEDICAL RECORDS	0	45,907	45,907	11.00
12.00	STAFF TRANSPORTATION	69,714		69,714	12.00
13.00	VOLUNTEER SERVICE COORDINATION	24,231		24,231	13.00
14.00	PHARMACY	152,532	45,241	197,773	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	231,976	0	231,976	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,446,720		1,446,720	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3,379		3,379	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	2,606		2,606	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	2,036,530	905,409	2,941,939	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS			Provider CCN: 14-0160 Hospice CCN: 14-1560		Period: From 01/01/2019 To 12/31/2019		Worksheet 0-6 Part I Date/Time Prepared: 8/25/2020 9:08 am	
Descriptions			TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	Hospice I EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
			0	1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	0	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	19,115			19,115			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	258,873	0		0	258,873		3.00
4.00	ADMINISTRATIVE & GENERAL	632,498	0		0	0	632,498	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0		0	0		5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0	0	0	6.00
7.00	HOUSEKEEPING	0	0		0	0	0	7.00
8.00	DIETARY	0	0		0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	9,147	0		0	0	9,147	10.00
11.00	MEDICAL RECORDS	45,907	0		0	0	45,907	11.00
12.00	STAFF TRANSPORTATION	69,714	0		0	0	69,714	12.00
13.00	VOLUNTEER SERVICE COORDINATION	24,231	0		0	0	24,231	13.00
14.00	PHARMACY	197,773	0		0	0	197,773	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0	0	0	15.00
16.00	OTHER GENERAL SERVICE	231,976	0		0	0	231,976	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0		0		0	17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0				0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,446,720				257,807	1,704,527	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3,379	0		10,791	602	14,772	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	2,606	0		8,324	464	11,394	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	0		0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0	0	0	61.00
62.00	FUNDRAISING	0	0		0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0		0	0	0	66.00
67.00	ADVERTISING	0	0		0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0	0	0	68.00
69.00	THRIFT STORE	0	0		0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0		0	0		99.00
100.00	TOTAL	2,941,939	0		19,115	258,873	2,941,939	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0160

Period:

Worksheet 0-6

Hospice CCN: 14-1560

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/25/2020 9:08 am

Descriptions		ADMINISTRATIVE & GENERAL		PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	Hospice I HOUSEKEEPING	DIETARY	
		4.00		5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMINISTRATIVE & GENERAL	632,498						4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0			6.00
7.00	HOUSEKEEPING	0	0			0		7.00
8.00	DIETARY	0	0			0	0	8.00
9.00	NURSING ADMINISTRATION	0	0			0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	2,505	0			0		10.00
11.00	MEDICAL RECORDS	12,573	0			0		11.00
12.00	STAFF TRANSPORTATION	19,093	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	6,636	0			0		13.00
14.00	PHARMACY	54,165	0			0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0			0		15.00
16.00	OTHER GENERAL SERVICE	63,532	0			0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0			0		17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0						50.00
51.00	HOSPICE ROUTINE HOME CARE	466,827						51.00
52.00	HOSPICE INPATIENT RESPITE CARE	4,046	0		0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	3,121	0		0	0	0	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	0			0		60.00
61.00	VOLUNTEER PROGRAM	0	0			0		61.00
62.00	FUNDRAISING	0	0			0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0			0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0			0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0			0		65.00
66.00	RESIDENTIAL CARE	0	0		0	0	0	66.00
67.00	ADVERTISING	0	0			0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0			0		68.00
69.00	THRIFT STORE	0	0			0		69.00
70.00	NURSING FACILITY ROOM & BOARD							70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0		0	0	0	99.00
100.00	TOTAL	632,498	0		0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0160

Period:

Worksheet 0-6

Hospice CCN: 14-1560

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/25/2020 9:08 am

Descriptions		Hospice I				
		NURSING ADMINISTRATIO N	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATIO N	VOLUNTEER SERVICE COORDINATION
		9.00	10.00	11.00	12.00	13.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION	0				9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	11,652			10.00
11.00	MEDICAL RECORDS	0		58,480		11.00
12.00	STAFF TRANSPORTATION	0			88,807	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	30,867 13.00
14.00	PHARMACY	0			0	0 14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0 15.00
16.00	OTHER GENERAL SERVICE	0			0	0 16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0 50.00
51.00	HOSPICE ROUTINE HOME CARE	0	11,604	58,239	88,441	30,740 51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	27	136	207	72 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	21	105	159	55 53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0 60.00
61.00	VOLUNTEER PROGRAM	0			0	0 61.00
62.00	FUNDRAISING	0			0	0 62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0 63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0 64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0 65.00
66.00	RESIDENTIAL CARE	0			0	0 66.00
67.00	ADVERTISING	0			0	0 67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0 68.00
69.00	THRIFT STORE	0			0	0 69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0 71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0 99.00
100.00	TOTAL	0	11,652	58,480	88,807	30,867 100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0160

Period:

Worksheet 0-6

Hospice CCN: 14-1560

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/25/2020 9:08 am

Descriptions		Hospice I				TOTAL	
		PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
		14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	251,938					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		295,508			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	250,900	0	294,291		2,905,569	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	586	0	687	0	20,533	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	452	0	530	0	15,837	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	251,938	0	295,508	0	2,941,939	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0160

Hospice CCN: 14-1560

Period:
From 01/01/2019
To 12/31/2019Worksheet 0-6
Part II
Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATIO N	ADMINISTRATIV E & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		62				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	15,050			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-632,498	2,309,441	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	9,147	10.00
11.00	MEDICAL RECORDS	0	0	0	0	45,907	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	69,714	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	24,231	13.00
14.00	PHARMACY	0	0	0	0	197,773	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	231,976	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			14,988	0	1,704,527	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	35	35	0	14,772	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	27	27	0	11,394	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	19,115	258,873		632,498	100.00
101.00	UNIT COST MULTIPLIER	0.000000	308.306452	17.200864		0.273875	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0160

Period:

Worksheet 0-6

Hospice CCN: 14-1560

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATIO N (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000	0.000000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0160

Period:

Worksheet 0-6

Hospice CCN: 14-1560

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Descriptions		Hospice I					
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	15,050					10.00
11.00	MEDICAL RECORDS		15,050				11.00
12.00	STAFF TRANSPORTATION			15,050			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	15,050		13.00
14.00	PHARMACY			0	0	15,050	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	14,988	14,988	14,988	14,988	14,988	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	35	35	35	35	35	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	27	27	27	27	27	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	11,652	58,480	88,807	30,867	251,938	100.00
101.00	UNIT COST MULTIPLIER	0.774219	3.885714	5.900797	2.050963	16.740066	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0160

Period:

Worksheet 0-6

Hospice CCN: 14-1560

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
8/25/2020 9:08 am

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		15,050			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	14,988			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	35	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	27	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	295,508	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	19.635083	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY
LEVEL OF CARE

Provider CCN: 14-0160

Period:

Worksheet 0-7

Hospice CCN: 14-1560

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

Date/Time Prepared:
8/25/2020 9:08 am

Hospice I

Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)				
				HCHC	HRHC	HIRC		
				0	1.00	2.00		3.00
1.00	ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.246204	0	0	0	1.00	
2.00	OCCUPATIONAL THERAPY	67.00					2.00	
3.00	SPEECH PATHOLOGY	68.00					3.00	
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.116252	0	192,858	0	4.00	
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00	
6.00	LABORATORY	60.00	0.126216	0	0	0	6.00	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.000000	0	0	0	7.00	
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00	
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00	
10.00	DIABETIC EDUCATION	76.00	1.381948	0	0	0	10.00	
10.01	CANCER CENTER	76.01	0.396947	0	0	0	10.01	
11.00	Totals (sum of lines 1-11)						11.00	
Cost Center Descriptions		Charges by LOC (from Provider Records)	Shared Service Costs by LOC					
			HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)		HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)
			5.00	6.00	7.00		8.00	9.00
1.00	ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00	
2.00	OCCUPATIONAL THERAPY						2.00	
3.00	SPEECH PATHOLOGY						3.00	
4.00	DRUGS CHARGED TO PATIENTS	0	0	22,420	0	0	4.00	
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00	
6.00	LABORATORY	0	0	0	0	0	6.00	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	7.00	
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00	
9.00	RADIOLOGY-THERAPEUTIC						9.00	
10.00	DIABETIC EDUCATION	0	0	0	0	0	10.00	
10.01	CANCER CENTER	0	0	0	0	0	10.01	
11.00	Totals (sum of lines 1-11)		0	22,420	0	0	11.00	

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0160

Period:

Worksheet 0-8

Hospice CCN: 14-1560

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/25/2020 9:08 am

		Hospice I			
		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			2,927,989	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			14,988	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			195.36	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	14,148	278		9.00
10.00	Program cost (line 8 times line 9)	2,763,953	54,310		10.00
HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			20,533	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			35	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			586.66	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	34	0		14.00
15.00	Program cost (line 13 times line 14)	19,946	0		15.00
HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			15,837	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			27	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			586.56	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	19	0		19.00
20.00	Program cost (line 18 times line 19)	11,145	0		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			2,964,359	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			15,050	22.00
23.00	Average cost per diem (line 21 divided by line 22)			196.97	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0160	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 8/25/2020 9:08 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		889,005	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		4,234	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		38.18	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		893,239	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00