

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interest on 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 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/30/2021 1:02 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/30/2021	Time: 1:02 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status	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 THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE 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 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) MICHAEL C CLARK

Officer or Administrator of Provider(s)

EVP 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	-96,952	-122,003	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	-96,952	-122,003	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 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 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.

Health Financial Systems		FHN MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10					
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN:14-0160		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/30/2021 1:02 pm	
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: FREEPOR			State: IL		Zip Code:64032		County: STEPHENSON	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			FHN MEMORIAL HOSPITAL	140160	99914	1	07/01/1966	N
4.00	Subprovider - IPF								P
5.00	Subprovider - IRF								O
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)						01/01/2020	12/31/2020	
21.00	Type of Control (see instructions)						2		
							1.00	2.00	
							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		
22.01	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		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid days	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.			1,581	651	0	15	0	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN:14-0160		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/30/2021 1:02 pm	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid days	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 Status	Date of Geographic Reclassification		
						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.					01/01/2020	12/31/2020		38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)						N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.						N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	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.								56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.								58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
				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 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/30/2021 1:02 pm

	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	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
63.00	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" N for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.					
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 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/30/2021 1:02 pm

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

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			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.			N 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 1.00	XIX 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.			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 91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N 92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N 93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N 94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00 95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N 96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00 97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y 98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y 98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y 98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N 98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N 98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y 98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y 98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?			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
			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 109.00

Health Financial Systems		FHN MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-0160	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/30/2021 1:02 pm	
			1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N			110.00
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model 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	615,274	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 §312N 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.	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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN:14-0160		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/30/2021 1:02 pm		
						1.00	2.00			
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.								146.00	
						1.00				
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N		149.00	
						Part A	Part B	Title V	Title XIX	
						1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital				N	N	N	N	155.00	
156.00	Subprovider - IPF				N	N	N	N	156.00	
157.00	Subprovider - IRF				N	N	N	N	157.00	
158.00	SUBPROVIDER								158.00	
159.00	SNF				N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY				N	N	N	N	160.00	
161.00	CMHC					N	N	N	161.00	
						1.00				
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N		165.00	
						Name	County	State	Zip Code	
						0	1.00	2.00	3.00	
						4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00	166.00
						1.00				
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						9.99		169.00	
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-0160	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/30/2021 1:02 pm
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)			N 0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN:14-0160	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/30/2021 1:02 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
			Y/N 1.00	Date 2.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
			Y/N 1.00	Type 2.00
			Date 2.00	V/I 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 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		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 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 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 Y/N 1.00	Part B Date 2.00
			Y/N 1.00	Date 2.00
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	06/29/2021	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

Health Financial Systems		FHN MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN:14-0160		Period: From 01/01/2020 To 12/31/2020	
		Worksheet S-2 Part II Date/Time Prepared: 7/30/2021 1:02 pm			
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N	N		20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				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?	Y			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N	12/31/2020		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	Y			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 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/30/2021 1:02 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/30/2021 1:02 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	92	33,672	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	33,672	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,928	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	36,600	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 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/30/2021 1:02 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,999	1,844	10,215			1.00
2.00 HMO and other (see instructions)	3,201	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)	3,999	1,844	10,215			7.00
8.00 INTENSIVE CARE UNIT	384	74	1,147			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		329	525			13.00
14.00 Total (see instructions)	4,383	2,247	11,887	0.00	515.15	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	17.65	24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	532.80	27.00
28.00 Observation Bed Days		0	5,496			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	124			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/30/2021 1:02 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,071	618	3,082	1.00
2.00 HMO and other (see instructions)			737	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	1,071	618	3,082	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 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/30/2021 1:02 pm

	Wkst. A Line Number	Amount Reported	Reclassification 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	35,812,185	0	35,812,185	1,130,191.83	31.69
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		2,488,458	0	2,488,458	25,644.50	97.04
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,054,579	17,275	1,071,854	38,202.73	28.06
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,468,512	0	1,468,512	22,750.82	64.55
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		6,000	0	6,000	92.00	65.22
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		4,869,597	0	4,869,597	128,845.22	37.79
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		9,186,909	0	9,186,909		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		321,809	0	321,809		
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		308,085	0	308,085		
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)		1,314,130	0	1,314,130		
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 01/01/2020
To 12/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/30/2021 1:02 pm

		Wkst. A Line Number	Amount Reported	Reclassification on 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	2,383,375	-7,360	2,376,015	106,754.87	22.26	27.00
28.00	Administrative & General under contract (see inst.)		147,459	0	147,459	1,088.60	135.46	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	317,953	0	317,953	19,180.10	16.58	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,701,622	0	1,701,622	120,315.25	14.14	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,130,006	0	1,130,006	67,777.98	16.67	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	646,542	0	646,542	15,760.78	41.02	38.00
39.00	Central Services and Supply	14.00	91,137	0	91,137	6,511.51	14.00	39.00
40.00	Pharmacy	15.00	1,094,455	0	1,094,455	31,131.07	35.16	40.00
41.00	Medical Records & Medical Records Library	16.00	1,331,643	0	1,331,643	47,548.85	28.01	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 01/01/2020
To 12/31/2020Worksheet S-3
Part III
Date/Time Prepared:
7/30/2021 1:02 pm

	Worksheet A Line Number	Amount Reported	Reclassification 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)	36,302,814	0	36,302,814	1,293,729.16	28.06	1.00
2.00	Excluded area salaries (see instructions)	1,054,579	17,275	1,071,854	38,202.73	28.06	2.00
3.00	Subtotal salaries (line 1 minus line 2)	35,248,235	-17,275	35,230,960	1,255,526.43	28.06	3.00
4.00	Subtotal other wages & related costs (see inst.)	6,344,109	0	6,344,109	151,688.04	41.82	4.00
5.00	Subtotal wage-related costs (see inst.)	10,501,039	0	10,501,039	0.00	29.81	5.00
6.00	Total (sum of lines 3 thru 5)	52,093,383	-17,275	52,076,108	1,407,214.47	37.01	6.00
7.00	Total overhead cost (see instructions)	8,844,192	-7,360	8,836,832	416,069.01	21.24	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part IV
Date/Time Prepared:
7/30/2021 1:02 pm

		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)	488,490	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	17,615	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)	6,448,512	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	-23,016	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	36,796	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)	50,816	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	211,874	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	2,547,564	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	55,767	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)	9,834,418	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 01/01/2020
To 12/31/2020Worksheet S-3
Part V
Date/Time Prepared:
7/30/2021 1:02 pm

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	1,468,512	9,834,418	1.00
2.00	Hospital	1,468,512	9,834,418	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 01/01/2020 To 12/31/2020	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 7/30/2021 1:02 pm
		Hospice I		

		Unduplicated Days	Hospice Care						
		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	0	10.00
11.00	Hospice Routine Home Care	14,719	118	806	15,643	11.00
12.00	Hospice Inpatient Respite Care	136	0	31	167	12.00
13.00	Hospice General Inpatient Care	20	0	13	33	13.00
14.00	Total Hospice Days	14,875	118	850	15,843	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

Health Financial Systems		FHN MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN:14-0160	Period: From 01/01/2020 To 12/31/2020	Worksheet S-10 Date/Time Prepared: 7/30/2021 1:02 pm	
			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.208216	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			8,967,574	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			2,657,954	5.00
6.00	Medicaid charges			80,677,622	6.00
7.00	Medicaid cost (line 1 times line 6)			16,798,372	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)			< 5,172,844	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 5, 17, 2, 8, 4, 4 and 16)			1272,844	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)	2,456,088	777,530	3,233,618	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	511,397	777,530	1,288,927	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)	511,397	777,530	1,288,927	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)			11,774,132	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			682,828	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,050,505	27.01
28.00	Non-Medicare bad debt expense (see instructions)			10,723,627	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			2,600,508	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			3,889,435	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			9,062,279	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020

Worksheet A

Date/Time Prepared:
7/30/2021 1:02 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	1,318,805	1,318,805	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,940,373	3,940,373	-1,318,805	2,621,568	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,834,440	9,834,440	0	9,834,440	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,383,375	19,903,237	22,286,612	-8,324	22,278,288	5.00
7.00	00700	OPERATION OF PLANT	317,953	2,905,652	3,223,605	0	3,223,605	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	328,318	328,318	0	328,318	8.00
9.00	00900	HOUSEKEEPING	0	2,036,067	2,036,067	0	2,036,067	9.00
10.00	01000	DIETARY	0	2,149,950	2,149,950	-941,867	1,208,083	10.00
11.00	01100	CAFETERIA	0	0	0	941,867	941,867	11.00
13.00	01300	NURSING ADMINISTRATION	646,542	191,911	838,453	0	838,453	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	91,137	388,788	479,925	0	479,925	14.00
15.00	01500	PHARMACY	1,094,455	4,699,533	5,793,988	-3,675,289	2,118,699	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,331,643	605,658	1,937,301	0	1,937,301	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,975,348	1,798,718	12,774,066	-10,681	12,763,385	30.00
31.00	03100	INTENSIVE CARE UNIT	1,337,233	396,134	1,733,367	0	1,733,367	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,735,397	6,713,797	8,449,194	0	8,449,194	50.00
50.01	05001	GI LAB	809,869	759,539	1,569,408	0	1,569,408	50.01
50.02	05002	AMBULATORY CARE UNIT	1,344,717	142,819	1,487,536	0	1,487,536	50.02
51.00	05100	RECOVERY ROOM	421,830	17,206	439,036	0	439,036	51.00
53.00	05300	ANESTHESIOLOGY	0	1,139,123	1,139,123	0	1,139,123	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,235,807	4,004,712	6,240,519	0	6,240,519	54.00
60.00	06000	LABORATORY	1,378,254	4,272,546	5,650,800	0	5,650,800	60.00
65.00	06500	RESPIRATORY THERAPY	837,655	302,078	1,139,733	0	1,139,733	65.00
66.00	06600	PHYSICAL THERAPY	2,391,587	108,376	2,499,963	0	2,499,963	66.00
69.00	06900	ELECTROCARDIOLOGY	219,067	350,389	569,456	0	569,456	69.00
69.01	06901	CATH LAB	507,927	620,247	1,128,174	0	1,128,174	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	3,675,289	3,675,289	73.00
74.00	07400	RENAL DIALYSIS	0	164,273	164,273	0	164,273	74.00
76.00	03950	DIABETIC EDUCATION	0	71,785	71,785	0	71,785	76.00
76.01	03480	CANCER CENTER	1,483,964	7,404,733	8,888,697	0	8,888,697	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	9,203	893,789	902,992	0	902,992	90.00
91.00	09100	EMERGENCY	3,204,643	5,355,339	8,559,982	0	8,559,982	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	1,054,579	1,211,551	2,266,130	0	2,266,130	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,812,185	82,711,081	118,523,266	-19,005	118,504,261	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	8,324	8,324	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	0	0	0	10,681	10,681	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	35,812,185	82,711,128	118,523,313	0	118,523,313	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020

Worksheet A

Date/Time Prepared:
7/30/2021 1:02 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	1,318,805	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	2,621,568	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,834,440	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,689,685	17,588,603	5.00
7.00	00700	OPERATION OF PLANT	0	3,223,605	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	328,318	8.00
9.00	00900	HOUSEKEEPING	0	2,036,067	9.00
10.00	01000	DIETARY	-10,331	1,197,752	10.00
11.00	01100	CAFETERIA	-1,375	940,492	11.00
13.00	01300	NURSING ADMINISTRATION	-55,072	783,381	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	479,925	14.00
15.00	01500	PHARMACY	0	2,118,699	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-831	1,936,470	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,837,836	9,925,549	30.00
31.00	03100	INTENSIVE CARE UNIT	-259,842	1,473,525	31.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-361,611	8,087,583	50.00
50.01	05001	GI LAB	0	1,569,408	50.01
50.02	05002	AMBULATORY CARE UNIT	0	1,487,536	50.02
51.00	05100	RECOVERY ROOM	383	439,419	51.00
53.00	05300	ANESTHESIOLOGY	-988,492	150,631	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,628,988	3,611,531	54.00
60.00	06000	LABORATORY	-435,051	5,215,749	60.00
65.00	06500	RESPIRATORY THERAPY	-59,290	1,080,443	65.00
66.00	06600	PHYSICAL THERAPY	-6,351	2,493,612	66.00
69.00	06900	ELECTROCARDIOLOGY	-251,364	318,092	69.00
69.01	06901	CATH LAB	-14,400	1,113,774	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	3,675,289	73.00
74.00	07400	RENAL DIALYSIS	0	164,273	74.00
76.00	03950	DIABETIC EDUCATION	0	71,785	76.00
76.01	03480	CANCER CENTER	-1,569,525	7,319,172	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	902,992	90.00
91.00	09100	EMERGENCY	-4,430,878	4,129,104	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	0	2,266,130	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-18,600,539	99,903,722	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	8,324	192.03
192.04	19204	SMART STEPS	0	0	192.04
192.05	19205	RESPITE CARE	0	10,681	192.05
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-18,600,539	99,922,774	200.00

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-6

Date/Time Prepared:
7/30/2021 1:02 pm

	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	3,675,289		
	TOTALS		0	3,675,289		
1.00	B - SHARED DIETARY EXPENSES					1.00
	CAFETERIA	11.00	0	941,867		
	TOTALS		0	941,867		
1.00	C - RESPITE CARE					1.00
	RESPITE CARE	192.05	9,915	766		
	TOTALS		9,915	766		
1.00	D - NON PATIENT VOLUNTEER ADMIN					1.00
	NA VOLUNTEER SERVICES	192.03	7,360	964		
	TOTALS		7,360	964		
1.00	E - BUILDING DEPRECIATION					1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	1,318,805		
	TOTALS		0	1,318,805		
500.00	Grand Total: Increases			17,275	5,937,691	500.00

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-6
Date/Time Prepared:
7/30/2021 1:02 pm

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
1.00	A - CHARGEABLE DRUGS						1.00
	PHARMACY	15.00	0	3,675,289	0		
	TOTALS		0	3,675,289			
1.00	B - SHARED DIETARY EXPENSES						1.00
	DIETARY	10.00	0	941,867	0		
	TOTALS		0	941,867			
1.00	C - RESPITE CARE						1.00
	ADULTS & PEDIATRICS	30.00	9,915	766	0		
	TOTALS		9,915	766			
1.00	D - NON PATIENT VOLUNTEER ADMIN						1.00
	ADMINISTRATIVE & GENERAL	5.00	7,360	964	0		
	TOTALS		7,360	964			
1.00	E - BUILDING DEPRECIATION						1.00
	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,318,805	9		
	TOTALS		0	1,318,805			
500.00	Grand Total: Decreases			17,275	5,937,691		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
7/30/2021 1:02 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	944,945	0	0	0	0	1.00
2.00	Land Improvements	1,949,200	0	0	0	0	2.00
3.00	Buildings and Fixtures	52,468,677	649,460	0	649,460	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,413,539	1,326,978	0	1,326,978	0	5.00
6.00	Movable Equipment	35,953,419	922,065	0	922,065	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)	95,976,470	2,898,503	0	2,898,503	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	95,976,470	2,898,503	0	2,898,503	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	53,118,137	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	2,740,517	0				5.00
6.00	Movable Equipment	36,875,484	0				6.00
7.00	HIT designated Assets	3,246,690	0				7.00
8.00	Subtotal (sum of lines 1-7)	98,874,973	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	98,874,973	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
7/30/2021 1:02 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,940,373	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,940,373	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,940,373				2.00
3.00	Total (sum of lines 1-2)	0	3,940,373				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
7/30/2021 1:02 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	61,999,488	0	61,999,488	0.627049	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	36,875,484	0	36,875,484	0.372951	0	2.00
3.00	Total (sum of lines 1-2)	98,874,972	0	98,874,972	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,318,805	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,621,568	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,940,373	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,318,805	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,621,568	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	3,940,373	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8

Date/Time Prepared:
7/30/2021 1:02 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0 1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0 2.00
3.00	Investment income - other (chapter 2)			0		0.00	0 3.00
4.00	Trade, quantity, and time discounts (chapter 8)			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	-14,104,155				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	425,269				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 employees and others			0		0.00	0 15.00
16.00	Sale of medical and surgical supplies to other than patients			0		0.00	0 16.00
17.00	Sale of drugs to other than patients			0		0.00	0 17.00
18.00	Sale of medical records and abstracts			0		0.00	0 18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0 19.00
20.00	Vending machines			0		0.00	0 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
28.00	Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant			0		0.00	0 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00	30.00
30.99	Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00	30.99
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

ADJUSTMENTS TO EXPENSES

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8

Date/Time Prepared:
7/30/2021 1:02 pm

Cost Center Description			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
1.00	2.00	3.00	4.00	5.00		
33.00	TRADE, QUANTITY AND TIME DISCOUNTS	B -8,853	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 -831	MEDICAL RECORDS & LIBRARY	16.00	0	33.03
33.04	VENDING MACHINES	B -1,375	CAFETERIA	11.00	0	33.04
33.05	DIETARY REVENUE	B 0	DIETARY	10.00	0	33.05
33.06	PHYSICIAN COLLECTIONS EXPENSES	A -68,326	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	DIETARY CONSULTING	B -363	DIETARY	10.00	0	33.07
33.08	TELEPHONE CAPITAL COSTS	A -62,130	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	TV CAPITAL COSTS	A -12,720	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	ASSOC LOBBYING FEES	A -28,571	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	MEALS ON WHEELS	B -9,968	DIETARY	10.00	0	33.11
33.12	HBP HOSPICE	A 0	HOSPICE	116.00	0	33.12
33.13	OTHER REVENUE MISC	B -1,027	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	OB MISC INCOME	B -29	ADULTS & PEDIATRICS	30.00	0	33.14
33.15	LIFELINE EXPENSE	A -1,144	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	LIFELINE DEPR	0		0.00	9	33.16
33.17	RENTAL INCOME	B -21,000	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY) (3)	0		0.00	0	33.18
33.19	NONPATIENT DIABETIC REVENUE	B 0	DIABETIC EDUCATION	76.00	0	33.19
33.20	RADIOLOGY MED RECORD REVENUE	B -55	RADIOLOGY-DIAGNOSTIC	54.00	0	33.20
33.21	PT, OT, SPORTS MED MISC INCOME	B -1,851	PHYSICAL THERAPY	66.00	0	33.21
33.22	PROVIDER TAX COST	A -4,703,034	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	MED SURG INCOME	B -376	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.)	-18,600,539				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 01/01/2020
To 12/31/2020

Worksheet A-8-1

Date/Time Prepared:
7/30/2021 1:02 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	CORPORATE ALLOCATION	12,160,687	11,735,418	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.			12,160,687	11,735,418	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 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 requested 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 01/01/2020 To 12/31/2020	Worksheet A-8-1 Date/Time Prepared: 7/30/2021 1:02 pm
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	Net Adjustment (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	425,269	0	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	425,269		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 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 requested 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 01/01/2020
To 12/31/2020

Worksheet A-8-2

Date/Time Prepared:
7/30/2021 1:02 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	902,997	902,997	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	259,842	259,842	0	0	0	2.00
3.00	50.00	OPERATING ROOM	99,611	99,611	0	0	0	3.00
4.00	13.00	NURSING ADMINISTRATION	55,072	55,072	0	0	0	4.00
5.00	50.01	GI LAB	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	2,628,933	2,628,933	0	0	0	6.00
7.00	60.00	LABORATORY	435,051	435,051	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	251,364	251,364	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	59,290	59,290	0	0	0	9.00
10.00	91.00	EMERGENCY	4,430,878	4,430,878	0	0	0	10.00
11.00	76.01	CANCER CENTER	1,569,525	1,569,525	0	0	0	11.00
12.00	30.00	ADULTS & PEDIATRICS	1,919,333	1,919,333	0	0	0	12.00
13.00	5.00	ADMINISTRATIVE & GENERAL	213,773	207,773	6,000	179,000	92	13.00
14.00	30.00	ADULTS & PEDIATRICS	15,477	15,477	0	0	0	14.00
15.00	69.01	CATH LAB	14,400	14,400	0	0	0	15.00
16.00	53.00	ANESTHESIOLOGY	988,492	988,492	0	0	0	16.00
17.00	50.00	OPERATING ROOM	262,000	262,000	0	0	0	17.00
18.00	66.00	PHYSICAL THERAPY	4,500	4,500	0	0	0	18.00
19.00	51.00	RECOVERY ROOM	-383	-383	0	0	0	19.00
200.00			14,110,155	14,104,155	6,000		92	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8-2

Date/Time Prepared:
7/30/2021 1:02 pm

	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	50.01	GI LAB	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	7,917	396	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
19.00	51.00	RECOVERY ROOM	0	0	0	0	0	19.00
200.00			7,917	396	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8-2

Date/Time Prepared:
7/30/2021 1:02 pm

	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	902,997		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	259,842		2.00
3.00	50.00	OPERATING ROOM	0	0	0	99,611		3.00
4.00	13.00	NURSING ADMINISTRATION	0	0	0	55,072		4.00
5.00	50.01	GI LAB	0	0	0	0		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	2,628,933		6.00
7.00	60.00	LABORATORY	0	0	0	435,051		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	251,364		8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	59,290		9.00
10.00	91.00	EMERGENCY	0	0	0	4,430,878		10.00
11.00	76.01	CANCER CENTER	0	0	0	1,569,525		11.00
12.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,919,333		12.00
13.00	5.00	ADMINISTRATIVE & GENERAL	0	7,917	0	207,773		13.00
14.00	30.00	ADULTS & PEDIATRICS	0	0	0	15,477		14.00
15.00	69.01	CATH LAB	0	0	0	14,400		15.00
16.00	53.00	ANESTHESIOLOGY	0	0	0	988,492		16.00
17.00	50.00	OPERATING ROOM	0	0	0	262,000		17.00
18.00	66.00	PHYSICAL THERAPY	0	0	0	4,500		18.00
19.00	51.00	RECOVERY ROOM	0	0	0	-383		19.00
200.00			0	7,917	0	14,104,155		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/30/2021 1:02 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,318,805	1,318,805			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,621,568		2,621,568		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,834,440	8,026	0	9,842,466	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,588,603	260,616	99,034	653,014	5.00
7.00	00700	OPERATION OF PLANT	3,223,605	144,186	25,128	87,385	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	328,318	9,661	0	0	8.00
9.00	00900	HOUSEKEEPING	2,036,067	21,195	0	0	9.00
10.00	01000	DIETARY	1,197,752	47,708	8,831	0	10.00
11.00	01100	CAFETERIA	940,492	40,717	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	783,381	1,540	9,025	177,693	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	479,925	3,684	5,268	25,048	14.00
15.00	01500	PHARMACY	2,118,699	10,016	219,724	300,796	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,936,470	18,051	0	365,983	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,925,549	234,999	207,090	3,013,684	30.00
31.00	03100	INTENSIVE CARE UNIT	1,473,525	17,807	41,833	367,520	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,087,583	100,525	258,849	476,950	50.00
50.01	05001	GI LAB	1,569,408	28,794	98,577	222,581	50.01
50.02	05002	AMBULATORY CARE UNIT	1,487,536	37,419	18,462	369,577	50.02
51.00	05100	RECOVERY ROOM	439,419	6,884	13,100	115,934	51.00
53.00	05300	ANESTHESIOLOGY	150,631	3,551	45,518	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,611,531	72,198	561,124	614,480	54.00
60.00	06000	LABORATORY	5,215,749	36,567	282,228	378,794	60.00
65.00	06500	RESPIRATORY THERAPY	1,080,443	35,053	92,789	230,218	65.00
66.00	06600	PHYSICAL THERAPY	2,493,612	64,394	121,056	657,294	66.00
69.00	06900	ELECTROCARDIOLOGY	318,092	2,704	40,029	60,207	69.00
69.01	06901	CATH LAB	1,113,774	2,567	63,822	139,597	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	3,675,289	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	164,273	1,271	0	0	74.00
76.00	03950	DIABETIC EDUCATION	71,785	1,737	179	0	76.00
76.01	03480	CANCER CENTER	7,319,172	34,227	195,012	407,847	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	902,992	12,108	10,225	2,529	90.00
91.00	09100	EMERGENCY	4,129,104	56,535	188,119	880,751	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	2,266,130	0	16,546	289,836	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,903,722	1,314,740	2,621,568	9,837,718	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	47	3,273	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	792	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	8,324	0	0	2,023	192.03
192.04	19204	SMART STEPS	0	0	0	0	192.04
192.05	19205	RESPIRE CARE	10,681	0	0	2,725	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)	99,922,774	1,318,805	2,621,568	9,842,466	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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7/30/2021 1:02 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,601,267				5.00
7.00	00700	OPERATION OF PLANT	796,074	4,276,378			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	77,308	45,600	460,887		8.00
9.00	00900	HOUSEKEEPING	470,572	100,045	0	2,627,879	9.00
10.00	01000	DIETARY	286,903	225,193	0	143,262	1,909,649
11.00	01100	CAFETERIA	224,439	192,194	0	122,270	0
13.00	01300	NURSING ADMINISTRATION	222,250	7,270	0	4,625	0
14.00	01400	CENTRAL SERVICES & SUPPLY	117,554	17,388	0	11,062	0
15.00	01500	PHARMACY	605,978	47,276	0	30,076	0
16.00	01600	MEDICAL RECORDS & LIBRARY	530,785	85,202	0	54,204	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,060,830	1,109,243	168,712	705,672	1,818,655
31.00	03100	INTENSIVE CARE UNIT	434,757	84,051	19,529	53,471	90,994
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,041,228	474,498	13,471	301,865	0
50.01	05001	GI LAB	439,029	135,911	23,765	86,464	0
50.02	05002	AMBULATORY CARE UNIT	437,573	176,624	23,510	112,364	0
51.00	05100	RECOVERY ROOM	131,601	32,493	13,570	20,672	0
53.00	05300	ANESTHESIOLOGY	45,679	16,762	0	10,663	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,111,509	340,788	60,271	216,802	0
60.00	06000	LABORATORY	1,352,599	172,605	0	109,808	0
65.00	06500	RESPIRATORY THERAPY	329,039	165,456	189	105,260	0
66.00	06600	PHYSICAL THERAPY	763,148	303,952	19,284	193,368	0
69.00	06900	ELECTROCARDIOLOGY	96,306	12,763	0	8,120	0
69.01	06901	CATH LAB	301,878	12,117	3,821	7,709	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	840,675	0	0	0	0
74.00	07400	RENAL DIALYSIS	37,866	5,998	0	3,816	0
76.00	03950	DIABETIC EDUCATION	16,858	8,199	0	5,216	0
76.01	03480	CANCER CENTER	1,819,891	161,559	0	102,780	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	212,235	57,151	0	36,358	0
91.00	09100	EMERGENCY	1,201,901	266,855	114,765	169,767	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	588,429	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,594,894	4,257,193	460,887	2,615,674	1,909,649
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	759	15,449	0	9,828	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	181	3,736	0	2,377	0
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0
192.02	19202	SENIOR PROGRAM	0	0	0	0	0
192.03	19203	NA VOLUNTEER SERVICES	2,367	0	0	0	0
192.04	19204	SMART STEPS	0	0	0	0	0
192.05	19205	RESPIRE CARE	3,066	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	18,601,267	4,276,378	460,887	2,627,879	1,909,649

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	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	1,520,112				11.00
13.00	01300	NURSING ADMINISTRATION	23,626	1,229,410			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,893	0	669,822		14.00
15.00	01500	PHARMACY	47,107	0	10,316	3,389,988	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	69,501	0	0	3,060,196	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	462,482	836,688	126,508	3,715	30.00
31.00	03100	INTENSIVE CARE UNIT	53,702	105,935	37,932	979	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	88,127	0	24,011	236,534	50.00
50.01	05001	GI LAB	36,780	0	64,994	817	50.01
50.02	05002	AMBULATORY CARE UNIT	56,565	0	36,407	3,636	50.02
51.00	05100	RECOVERY ROOM	14,712	0	1,697	509	51.00
53.00	05300	ANESTHESIOLOGY	0	0	34,559	4,629	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	136,683	0	57,863	2,383	54.00
60.00	06000	LABORATORY	80,046	0	47,783	662	60.00
65.00	06500	RESPIRATORY THERAPY	43,339	0	32,953	2,871	65.00
66.00	06600	PHYSICAL THERAPY	110,883	0	11,005	43	66.00
69.00	06900	ELECTROCARDIOLOGY	8,588	0	523	0	69.00
69.01	06901	CATH LAB	19,713	0	652	103	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	1,235,914	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	DIABETIC EDUCATION	0	0	24	0	76.00
76.01	03480	CANCER CENTER	53,014	0	28,295	1,824,878	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	399	0	45,856	6,337	90.00
91.00	09100	EMERGENCY	147,300	286,787	96,783	1,980	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	56,492	0	11,661	63,998	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,518,952	1,229,410	669,822	3,389,988	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	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	580	0	0	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	192.04
192.05	19205	RESPITE CARE	580	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	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,520,112	1,229,410	669,822	3,389,988	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
7/30/2021 1:02 pm

	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	21,872,606	0	21,872,606	30.00
31.00	03100	INTENSIVE CARE UNIT	2,806,018	0	2,806,018	31.00
43.00	04300	NURSERY	0	0	0	43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	12,551,525	0	12,551,525	50.00
50.01	05001	GI LAB	2,844,807	0	2,844,807	50.01
50.02	05002	AMBULATORY CARE UNIT	2,767,301	0	2,767,301	50.02
51.00	05100	RECOVERY ROOM	806,465	0	806,465	51.00
53.00	05300	ANESTHESIOLOGY	359,447	0	359,447	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,362,290	0	7,362,290	54.00
60.00	06000	LABORATORY	8,032,167	0	8,032,167	60.00
65.00	06500	RESPIRATORY THERAPY	2,201,160	0	2,201,160	65.00
66.00	06600	PHYSICAL THERAPY	4,848,720	0	4,848,720	66.00
69.00	06900	ELECTROCARDIOLOGY	614,841	0	614,841	69.00
69.01	06901	CATH LAB	1,737,628	0	1,737,628	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	153	0	153	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,115,621	0	6,115,621	73.00
74.00	07400	RENAL DIALYSIS	216,940	0	216,940	74.00
76.00	03950	DIABETIC EDUCATION	104,459	0	104,459	76.00
76.01	03480	CANCER CENTER	12,147,166	0	12,147,166	76.01
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,333,052	0	1,333,052	90.00
91.00	09100	EMERGENCY	7,794,869	0	7,794,869	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	3,338,751	0	3,338,751	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,855,986	0	99,855,986	118.00
	NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	29,356	0	29,356	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,086	0	7,086	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	13,294	0	13,294	192.03
192.04	19204	SMART STEPS	0	0	0	192.04
192.05	19205	RESPIRE CARE	17,052	0	17,052	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)	99,922,774	0	99,922,774	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			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	8,026	0	8,026	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	260,616	99,034	359,650	532 5.00
7.00	00700	OPERATION OF PLANT	0	144,186	25,128	169,314	71 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,661	0	9,661	0 8.00
9.00	00900	HOUSEKEEPING	0	21,195	0	21,195	0 9.00
10.00	01000	DIETARY	0	47,708	8,831	56,539	0 10.00
11.00	01100	CAFETERIA	0	40,717	0	40,717	0 11.00
13.00	01300	NURSING ADMINISTRATION	0	1,540	9,025	10,565	145 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,684	5,268	8,952	20 14.00
15.00	01500	PHARMACY	0	10,016	219,724	229,740	245 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,051	0	18,051	298 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	234,999	207,090	442,089	2,461 30.00
31.00	03100	INTENSIVE CARE UNIT	0	17,807	41,833	59,640	300 31.00
43.00	04300	NURSERY	0	0	0	0	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	100,525	258,849	359,374	389 50.00
50.01	05001	GI LAB	0	28,794	98,577	127,371	181 50.01
50.02	05002	AMBULATORY CARE UNIT	0	37,419	18,462	55,881	301 50.02
51.00	05100	RECOVERY ROOM	0	6,884	13,100	19,984	94 51.00
53.00	05300	ANESTHESIOLOGY	0	3,551	45,518	49,069	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	72,198	561,124	633,322	501 54.00
60.00	06000	LABORATORY	0	36,567	282,228	318,795	309 60.00
65.00	06500	RESPIRATORY THERAPY	0	35,053	92,789	127,842	188 65.00
66.00	06600	PHYSICAL THERAPY	0	64,394	121,056	185,450	536 66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,704	40,029	42,733	49 69.00
69.01	06901	CATH LAB	0	2,567	63,822	66,389	114 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	1,271	0	1,271	0 74.00
76.00	03950	DIABETIC EDUCATION	0	1,737	179	1,916	0 76.00
76.01	03480	CANCER CENTER	0	34,227	195,012	229,239	332 76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	12,108	10,225	22,333	2 90.00
91.00	09100	EMERGENCY	0	56,535	188,119	244,654	718 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	16,546	16,546	236 116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,314,740	2,621,568	3,936,308	8,022 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,273	0	3,273	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	792	0	792	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	0	2 192.03
192.04	19204	SMART STEPS	0	0	0	0	0 192.04
192.05	19205	RESPIRE CARE	0	0	0	0	2 192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0 193.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,318,805	2,621,568	3,940,373	8,026 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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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	360,182				5.00
7.00	00700	OPERATION OF PLANT	15,414	184,799			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,497	1,971	13,129		8.00
9.00	00900	HOUSEKEEPING	9,112	4,323	0	34,630	9.00
10.00	01000	DIETARY	5,555	9,731	0	1,888	73,713
11.00	01100	CAFETERIA	4,346	8,305	0	1,611	0
13.00	01300	NURSING ADMINISTRATION	4,303	314	0	61	0
14.00	01400	CENTRAL SERVICES & SUPPLY	2,276	751	0	146	0
15.00	01500	PHARMACY	11,733	2,043	0	396	0
16.00	01600	MEDICAL RECORDS & LIBRARY	10,278	3,682	0	714	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	59,276	47,935	4,806	9,300	70,201
31.00	03100	INTENSIVE CARE UNIT	8,418	3,632	556	705	3,512
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	39,524	20,505	384	3,978	0
50.01	05001	GI LAB	8,501	5,873	677	1,139	0
50.02	05002	AMBULATORY CARE UNIT	8,473	7,633	670	1,481	0
51.00	05100	RECOVERY ROOM	2,548	1,404	387	272	0
53.00	05300	ANESTHESIOLOGY	884	724	0	141	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,522	14,727	1,717	2,857	0
60.00	06000	LABORATORY	26,190	7,459	0	1,447	0
65.00	06500	RESPIRATORY THERAPY	6,371	7,150	5	1,387	0
66.00	06600	PHYSICAL THERAPY	14,777	13,135	549	2,548	0
69.00	06900	ELECTROCARDIOLOGY	1,865	552	0	107	0
69.01	06901	CATH LAB	5,845	524	109	102	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	16,278	0	0	0	0
74.00	07400	RENAL DIALYSIS	733	259	0	50	0
76.00	03950	DIABETIC EDUCATION	326	354	0	69	0
76.01	03480	CANCER CENTER	35,238	6,982	0	1,354	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	4,109	2,470	0	479	0
91.00	09100	EMERGENCY	23,272	11,532	3,269	2,237	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	11,394	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	360,058	183,970	13,129	34,469	73,713
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15	668	0	130	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4	161	0	31	0
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	0
192.02	19202	SENIOR PROGRAM	0	0	0	0	0
192.03	19203	NA VOLUNTEER SERVICES	46	0	0	0	0
192.04	19204	SMART STEPS	0	0	0	0	0
192.05	19205	RESPIRE CARE	59	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	360,182	184,799	13,129	34,630	73,713

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	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	54,979					11.00
13.00	01300	NURSING ADMINISTRATION	855	16,243				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	358	0	12,503			14.00
15.00	01500	PHARMACY	1,704	0	193	246,054		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,514	0	0	0	35,537	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,727	11,054	2,362	270	2,305	30.00
31.00	03100	INTENSIVE CARE UNIT	1,942	1,400	708	71	278	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,187	0	448	17,168	5,194	50.00
50.01	05001	GI LAB	1,330	0	1,213	59	1,597	50.01
50.02	05002	AMBULATORY CARE UNIT	2,046	0	680	264	88	50.02
51.00	05100	RECOVERY ROOM	532	0	32	37	184	51.00
53.00	05300	ANESTHESIOLOGY	0	0	645	336	550	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,944	0	1,080	173	6,736	54.00
60.00	06000	LABORATORY	2,895	0	892	48	4,121	60.00
65.00	06500	RESPIRATORY THERAPY	1,567	0	615	208	969	65.00
66.00	06600	PHYSICAL THERAPY	4,010	0	205	3	1,284	66.00
69.00	06900	ELECTROCARDIOLOGY	311	0	10	0	783	69.00
69.01	06901	CATH LAB	713	0	12	7	834	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	2	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	89,706	4,218	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	43	74.00
76.00	03950	DIABETIC EDUCATION	0	0	0	0	5	76.00
76.01	03480	CANCER CENTER	1,917	0	528	132,455	2,325	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	14	0	856	460	543	90.00
91.00	09100	EMERGENCY	5,328	3,789	1,806	144	2,948	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	2,043	0	218	4,645	530	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,937	16,243	12,503	246,054	35,537	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	21	0	0	0	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	21	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)	54,979	16,243	12,503	246,054	35,537	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/30/2021 1:02 pm

	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	668,786	0	668,786	30.00
31.00	03100	INTENSIVE CARE UNIT	81,162	0	81,162	31.00
43.00	04300	NURSERY	0	0	0	43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	450,151	0	450,151	50.00
50.01	05001	GI LAB	147,941	0	147,941	50.01
50.02	05002	AMBULATORY CARE UNIT	77,517	0	77,517	50.02
51.00	05100	RECOVERY ROOM	25,474	0	25,474	51.00
53.00	05300	ANESTHESIOLOGY	52,349	0	52,349	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	687,579	0	687,579	54.00
60.00	06000	LABORATORY	362,156	0	362,156	60.00
65.00	06500	RESPIRATORY THERAPY	146,302	0	146,302	65.00
66.00	06600	PHYSICAL THERAPY	222,497	0	222,497	66.00
69.00	06900	ELECTROCARDIOLOGY	46,410	0	46,410	69.00
69.01	06901	CATH LAB	74,649	0	74,649	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2	0	2	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	110,202	0	110,202	73.00
74.00	07400	RENAL DIALYSIS	2,356	0	2,356	74.00
76.00	03950	DIABETIC EDUCATION	2,670	0	2,670	76.00
76.01	03480	CANCER CENTER	410,370	0	410,370	76.01
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	31,266	0	31,266	90.00
91.00	09100	EMERGENCY	299,697	0	299,697	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	35,612	0	35,612	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,935,148	0	3,935,148	118.00
	NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,086	0	4,086	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	988	0	988	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	69	0	69	192.03
192.04	19204	SMART STEPS	0	0	0	192.04
192.05	19205	RESPIRE CARE	82	0	82	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)	3,940,373	0	3,940,373	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/30/2021 1:02 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	308,248				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,621,574			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,876	0	35,812,185		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	60,915	99,034	2,376,015	-18,601,267	5.00
7.00	00700	OPERATION OF PLANT	33,701	25,128	317,953	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,258	0	0	0	8.00
9.00	00900	HOUSEKEEPING	4,954	0	0	0	9.00
10.00	01000	DIETARY	11,151	8,831	0	0	10.00
11.00	01100	CAFETERIA	9,517	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	360	9,025	646,542	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	861	5,268	91,137	0	14.00
15.00	01500	PHARMACY	2,341	219,724	1,094,455	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,219	0	1,331,643	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	54,927	207,090	10,965,433	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,162	41,833	1,337,233	0	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	23,496	258,850	1,735,397	0	50.00
50.01	05001	GI LAB	6,730	98,577	809,869	0	50.01
50.02	05002	AMBULATORY CARE UNIT	8,746	18,462	1,344,717	0	50.02
51.00	05100	RECOVERY ROOM	1,609	13,100	421,830	0	51.00
53.00	05300	ANESTHESIOLOGY	830	45,518	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,875	561,128	2,235,807	0	54.00
60.00	06000	LABORATORY	8,547	282,229	1,378,254	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,193	92,789	837,655	0	65.00
66.00	06600	PHYSICAL THERAPY	15,051	121,056	2,391,587	0	66.00
69.00	06900	ELECTROCARDIOLOGY	632	40,029	219,067	0	69.00
69.01	06901	CATH LAB	600	63,822	507,927	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	195,012	1,483,964	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,830	10,225	9,203	0	90.00
91.00	09100	EMERGENCY	13,214	188,119	3,204,643	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	16,546	1,054,579	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	307,298	2,621,574	35,794,910	-18,601,267	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	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	7,360	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	192.04
192.05	19205	RESPITE CARE	0	0	9,915	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)	1,318,805	2,621,568	9,842,466	18,601,267	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.278389	0.999998	0.274836	0.228737	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			8,026	360,182	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000224	0.004429	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 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/30/2021 1:02 pm

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	211,756				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,258	470,823			8.00
9.00	00900	HOUSEKEEPING	4,954	0	204,544		9.00
10.00	01000	DIETARY	11,151	0	11,151	55,740	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	172,350	54,927	53,084	30.00
31.00	03100	INTENSIVE CARE UNIT	4,162	19,950	4,162	2,656	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	23,496	13,761	23,496	0	50.00
50.01	05001	GI LAB	6,730	24,277	6,730	0	50.01
50.02	05002	AMBULATORY CARE UNIT	8,746	24,017	8,746	0	50.02
51.00	05100	RECOVERY ROOM	1,609	13,863	1,609	0	51.00
53.00	05300	ANESTHESIOLOGY	830	0	830	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,875	61,570	16,875	0	54.00
60.00	06000	LABORATORY	8,547	0	8,547	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,193	193	8,193	0	65.00
66.00	06600	PHYSICAL THERAPY	15,051	19,700	15,051	0	66.00
69.00	06900	ELECTROCARDIOLOGY	632	0	632	0	69.00
69.01	06901	CATH LAB	600	3,903	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	2,830	0	2,830	0	90.00
91.00	09100	EMERGENCY	13,214	117,239	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)	210,806	470,823	203,594	55,740	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	RESPITE 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)	4,276,378	460,887	2,627,879	1,909,649	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.194837	0.978897	12.847500	34.259939	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	184,799	13,129	34,630	73,713	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.872698	0.027885	0.169303	1.322443	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 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/30/2021 1:02 pm

Cost Center Description		NURSING ADMINISTRATION (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	400,580				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,987,676			14.00
15.00	01500	PHARMACY	0	30,611	9,880,863		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	479,577,733	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	272,619	375,416	10,828	31,151,638	30.00
31.00	03100	INTENSIVE CARE UNIT	34,517	112,562	2,854	3,758,504	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	71,252	689,432	70,190,230	50.00
50.01	05001	GI LAB	0	192,867	2,381	21,577,655	50.01
50.02	05002	AMBULATORY CARE UNIT	0	108,037	10,597	1,195,366	50.02
51.00	05100	RECOVERY ROOM	0	5,035	1,483	2,487,737	51.00
53.00	05300	ANESTHESIOLOGY	0	102,552	13,493	7,436,943	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	171,706	6,947	90,369,639	54.00
60.00	06000	LABORATORY	0	141,794	1,929	55,684,976	60.00
65.00	06500	RESPIRATORY THERAPY	0	97,787	8,367	13,093,632	65.00
66.00	06600	PHYSICAL THERAPY	0	32,657	126	17,345,447	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,552	0	10,579,629	69.00
69.01	06901	CATH LAB	0	1,934	300	11,263,844	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	23,994	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	3,602,346	57,003,999	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	582,374	74.00
76.00	03950	DIABETIC EDUCATION	0	70	0	72,190	76.00
76.01	03480	CANCER CENTER	0	83,964	5,319,002	31,420,010	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	136,076	18,470	7,344,059	90.00
91.00	09100	EMERGENCY	93,444	287,200	5,772	39,840,453	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	34,604	186,536	7,155,414	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	400,580	1,987,676	9,880,863	479,577,733	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	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	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)	1,229,410	669,822	3,389,988	3,060,196	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.069075	0.336988	0.343086	0.006381	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	16,243	12,503	246,054	35,537	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.040549	0.006290	0.024902	0.000074	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

Worksheet C
Part I
Date/Time Prepared:
7/30/2021 1:02 pm

MCRIF32 - 16.10.172.3

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/30/2021 1:02 pm

					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	23,207,371		23,207,371			30.00		
31.00	03100	INTENSIVE CARE UNIT	3,758,504		3,758,504			31.00		
43.00	04300	NURSERY	0		0			43.00		
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	32,291,012	37,899,218	70,190,230	0.178822	0.000000	50.00		
50.01	05001	GI LAB	3,152,707	18,424,948	21,577,655	0.131840	0.000000	50.01		
50.02	05002	AMBULATORY CARE UNIT	13,292	1,182,074	1,195,366	2.315024	0.000000	50.02		
51.00	05100	RECOVERY ROOM	974,846	1,512,891	2,487,737	0.324176	0.000000	51.00		
53.00	05300	ANESTHESIOLOGY	2,568,323	4,868,620	7,436,943	0.048333	0.000000	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,697,618	75,672,021	90,369,639	0.081469	0.000000	54.00		
60.00	06000	LABORATORY	12,497,707	43,187,269	55,684,976	0.144243	0.000000	60.00		
65.00	06500	RESPIRATORY THERAPY	9,440,061	3,653,571	13,093,632	0.168109	0.000000	65.00		
66.00	06600	PHYSICAL THERAPY	3,091,523	14,253,924	17,345,447	0.279538	0.000000	66.00		
69.00	06900	ELECTROCARDIOLOGY	2,946,649	7,632,980	10,579,629	0.058116	0.000000	69.00		
69.01	06901	CATH LAB	3,683,652	7,580,192	11,263,844	0.154266	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	21,408	2,586	23,994	0.006377	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	27,897,242	29,106,757	57,003,999	0.107284	0.000000	73.00		
74.00	07400	RENAL DIALYSIS	516,900	65,474	582,374	0.372510	0.000000	74.00		
76.00	03950	DIABETIC EDUCATION	0	72,190	72,190	1.447001	0.000000	76.00		
76.01	03480	CANCER CENTER	5,037	31,414,973	31,420,010	0.386606	0.000000	76.01		
	OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	3,860	7,340,199	7,344,059	0.181514	0.000000	90.00		
91.00	09100	EMERGENCY	6,999,232	32,841,221	39,840,453	0.195652	0.000000	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,490,448	6,453,819	7,944,267	0.963137	0.000000	92.00		
	SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00		
116.00	11600	HOSPICE	8,000	7,147,414	7,155,414			116.00		
200.00		Subtotal (see instructions)	149,265,392	330,312,341	479,577,733			200.00		
201.00		Less Observation Beds						201.00		
202.00		Total (see instructions)	149,265,392	330,312,341	479,577,733			202.00		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/30/2021 1:02 pm

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	0.178822		50.00
50.01	05001	GI LAB	0.131840		50.01
50.02	05002	AMBULATORY CARE UNIT	2.315024		50.02
51.00	05100	RECOVERY ROOM	0.324176		51.00
53.00	05300	ANESTHESIOLOGY	0.048333		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.081469		54.00
60.00	06000	LABORATORY	0.144243		60.00
65.00	06500	RESPIRATORY THERAPY	0.168109		65.00
66.00	06600	PHYSICAL THERAPY	0.279538		66.00
69.00	06900	ELECTROCARDIOLOGY	0.058116		69.00
69.01	06901	CATH LAB	0.154266		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.006377		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.107284		73.00
74.00	07400	RENAL DIALYSIS	0.372510		74.00
76.00	03950	DIABETIC EDUCATION	1.447001		76.00
76.01	03480	CANCER CENTER	0.386606		76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.181514		90.00
91.00	09100	EMERGENCY	0.195652		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.963137		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

Worksheet C
Part I
Date/Time Prepared:
7/30/2021 1:02 pm

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/30/2021 1:02 pm

					Title XIX		Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
			Inpatient	Outpatient	Total (col. 6 + col. 7)					
			6.00	7.00	8.00					
	INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	23,207,371		23,207,371			30.00		
31.00	03100	INTENSIVE CARE UNIT	3,758,504		3,758,504			31.00		
43.00	04300	NURSERY	0		0			43.00		
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	32,291,012	37,899,218	70,190,230	0.178822	0.000000	50.00		
50.01	05001	GI LAB	3,152,707	18,424,948	21,577,655	0.131840	0.000000	50.01		
50.02	05002	AMBULATORY CARE UNIT	13,292	1,182,074	1,195,366	2.315024	0.000000	50.02		
51.00	05100	RECOVERY ROOM	974,846	1,512,891	2,487,737	0.324176	0.000000	51.00		
53.00	05300	ANESTHESIOLOGY	2,568,323	4,868,620	7,436,943	0.048333	0.000000	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,697,618	75,672,021	90,369,639	0.081469	0.000000	54.00		
60.00	06000	LABORATORY	12,497,707	43,187,269	55,684,976	0.144243	0.000000	60.00		
65.00	06500	RESPIRATORY THERAPY	9,440,061	3,653,571	13,093,632	0.168109	0.000000	65.00		
66.00	06600	PHYSICAL THERAPY	3,091,523	14,253,924	17,345,447	0.279538	0.000000	66.00		
69.00	06900	ELECTROCARDIOLOGY	2,946,649	7,632,980	10,579,629	0.058116	0.000000	69.00		
69.01	06901	CATH LAB	3,683,652	7,580,192	11,263,844	0.154266	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	21,408	2,586	23,994	0.006377	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	27,897,242	29,106,757	57,003,999	0.107284	0.000000	73.00		
74.00	07400	RENAL DIALYSIS	516,900	65,474	582,374	0.372510	0.000000	74.00		
76.00	03950	DIABETIC EDUCATION	0	72,190	72,190	1.447001	0.000000	76.00		
76.01	03480	CANCER CENTER	5,037	31,414,973	31,420,010	0.386606	0.000000	76.01		
	OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	3,860	7,340,199	7,344,059	0.181514	0.000000	90.00		
91.00	09100	EMERGENCY	6,999,232	32,841,221	39,840,453	0.195652	0.000000	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,490,448	6,453,819	7,944,267	0.963137	0.000000	92.00		
	SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00		
116.00	11600	HOSPICE	8,000	7,147,414	7,155,414			116.00		
200.00		Subtotal (see instructions)	149,265,392	330,312,341	479,577,733			200.00		
201.00		Less Observation Beds						201.00		
202.00		Total (see instructions)	149,265,392	330,312,341	479,577,733			202.00		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/30/2021 1:02 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
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 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/30/2021 1:02 pm

			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	668,786	0	668,786	15,711	42.57	30.00
31.00	INTENSIVE CARE UNIT	81,162		81,162	1,147	70.76	31.00
43.00	NURSERY	0		0	525	0.00	43.00
200.00	Total (lines 30 through 199)	749,948		749,948	17,383		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	3,999	170,237				30.00
31.00	INTENSIVE CARE UNIT	384	27,172				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	4,383	197,409				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN:14-0160	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prepared: 7/30/2021 1:02 pm		
				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	450,151	70,190,230	0.006413	10,867,407	69,693	50.00
50.01	05001	GI LAB	147,941	21,577,655	0.006856	1,256,851	8,617	50.01
50.02	05002	AMBULATORY CARE UNIT	77,517	1,195,366	0.064848	2,296	149	50.02
51.00	05100	RECOVERY ROOM	25,474	2,487,737	0.010240	300,506	3,077	51.00
53.00	05300	ANESTHESIOLOGY	52,349	7,436,943	0.007039	799,804	5,630	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	687,579	90,369,639	0.007609	5,970,936	45,433	54.00
60.00	06000	LABORATORY	362,156	55,684,976	0.006504	4,778,196	31,077	60.00
65.00	06500	RESPIRATORY THERAPY	146,302	13,093,632	0.011174	3,793,465	42,388	65.00
66.00	06600	PHYSICAL THERAPY	222,497	17,345,447	0.012827	1,303,676	16,722	66.00
69.00	06900	ELECTROCARDIOLOGY	46,410	10,579,629	0.004387	1,257,516	5,517	69.00
69.01	06901	CATH LAB	74,649	11,263,844	0.006627	1,715,504	11,369	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2	23,994	0.000083	7,354	1	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	110,202	57,003,999	0.001933	10,098,240	19,520	73.00
74.00	07400	RENAL DIALYSIS	2,356	582,374	0.004046	290,011	1,173	74.00
76.00	03950	DIABETIC EDUCATION	2,670	72,190	0.036986	0	0	76.00
76.01	03480	CANCER CENTER	410,370	31,420,010	0.013061	2,971	39	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	31,266	7,344,059	0.004257	2,587	11	90.00
91.00	09100	EMERGENCY	299,697	39,840,453	0.007522	2,689,363	20,229	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	233,950	7,944,267	0.029449	616,663	18,160	92.00
200.00		Total (lines 50 through 199)	3,383,538	445,456,444		45,753,346	298,805	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN:14-0160		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/30/2021 1:02 pm		
					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	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	15,711	0.00	3,999			30.00	
31.00	03100	INTENSIVE CARE UNIT		0	1,147	0.00	384			31.00	
43.00	04300	NURSERY		0	525	0.00	0			43.00	
200.00		Total (lines 30 through 199)		0	17,383		4,383			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 01/01/2020
To 12/31/2020

Worksheet D
Part IV
Date/Time Prepared:
7/30/2021 1:02 pm

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020

Worksheet D
Part IV
Date/Time Prepared:
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					Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)		
									4.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	70,190,230	0.000000	50.00	
50.01	05001	GI LAB	0	0	0	21,577,655	0.000000	50.01	
50.02	05002	AMBULATORY CARE UNIT	0	0	0	1,195,366	0.000000	50.02	
51.00	05100	RECOVERY ROOM	0	0	0	2,487,737	0.000000	51.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	7,436,943	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	90,369,639	0.000000	54.00	
60.00	06000	LABORATORY	0	0	0	55,684,976	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,093,632	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	17,345,447	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10,579,629	0.000000	69.00	
69.01	06901	CATH LAB	0	0	0	11,263,844	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	23,994	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	57,003,999	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	582,374	0.000000	74.00	
76.00	03950	DIABETIC EDUCATION	0	0	0	72,190	0.000000	76.00	
76.01	03480	CANCER CENTER	0	0	0	31,420,010	0.000000	76.01	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	7,344,059	0.000000	90.00	
91.00	09100	EMERGENCY	0	0	0	39,840,453	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,944,267	0.000000	92.00	
200.00		Total (lines 50 through 199)	0	0	0	445,456,444		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020

Worksheet D
Part IV
Date/Time Prepared:
7/30/2021 1:02 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	10,867,407	0	8,595,476	0	50.00
50.01	05001	GI LAB	0.000000	1,256,851	0	5,388,423	0	50.01
50.02	05002	AMBULATORY CARE UNIT	0.000000	2,296	0	379,703	0	50.02
51.00	05100	RECOVERY ROOM	0.000000	300,506	0	261,141	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	799,804	0	1,079,447	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	5,970,936	0	19,406,087	0	54.00
60.00	06000	LABORATORY	0.000000	4,778,196	0	4,899,567	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,793,465	0	1,139,364	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,303,676	0	989,538	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,257,516	0	2,448,023	0	69.00
69.01	06901	CATH LAB	0.000000	1,715,504	0	2,491,476	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	7,354	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	10,098,240	0	8,564,802	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	290,011	0	22,967	0	74.00
76.00	03950	DIABETIC EDUCATION	0.000000	0	0	0	0	76.00
76.01	03480	CANCER CENTER	0.000000	2,971	0	12,470,243	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	2,587	0	4,099,425	0	90.00
91.00	09100	EMERGENCY	0.000000	2,689,363	0	6,230,411	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	616,663	0	2,309,670	0	92.00
200.00		Total (lines 50 through 199)		45,753,346	0	80,775,763	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN:14-0160		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 7/30/2021 1:02 pm	
			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	0.178822	8,595,476	0	5,195	1,537,060	50.00
50.01	05001	GI LAB	0.131840	5,388,423	0	0	710,410	50.01
50.02	05002	AMBULATORY CARE UNIT	2.315024	379,703	0	0	879,022	50.02
51.00	05100	RECOVERY ROOM	0.324176	261,141	0	0	84,656	51.00
53.00	05300	ANESTHESIOLOGY	0.048333	1,079,447	0	0	52,173	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.081469	19,406,087	0	1,581	1,580,995	54.00
60.00	06000	LABORATORY	0.144243	4,899,567	0	0	706,728	60.00
65.00	06500	RESPIRATORY THERAPY	0.168109	1,139,364	0	0	191,537	65.00
66.00	06600	PHYSICAL THERAPY	0.279538	989,538	0	0	276,613	66.00
69.00	06900	ELECTROCARDIOLOGY	0.058116	2,448,023	0	0	142,269	69.00
69.01	06901	CATH LAB	0.154266	2,491,476	0	0	384,350	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.006377	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	0.107284	8,564,802	0	36,848	918,866	73.00
74.00	07400	RENAL DIALYSIS	0.372510	22,967	0	0	8,555	74.00
76.00	03950	DIABETIC EDUCATION	1.447001	0	0	0	0	76.00
76.01	03480	CANCER CENTER	0.386606	12,470,243	0	33,046	4,821,071	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.181514	4,099,425	0	4,250	744,103	90.00
91.00	09100	EMERGENCY	0.195652	6,230,411	0	0	1,218,992	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.963137	2,309,670	0	0	2,224,529	92.00
200.00		Subtotal (see instructions)		80,775,763	0	80,920	16,481,929	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
201.00		Only Charges						
202.00		Net Charges (line 200 - line 201)		80,775,763	0	80,920	16,481,929	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/30/2021 1:02 pm

				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	929		50.00
50.01	05001	GI LAB	0	0		50.01
50.02	05002	AMBULATORY CARE UNIT	0	0		50.02
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	129		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CATH LAB	0	0		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	3,953		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	DIABETIC EDUCATION	0	0		76.00
76.01	03480	CANCER CENTER	0	12,776		76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	771		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	18,558		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	18,558		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN:14-0160	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/30/2021 1:02 pm
Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		15,711	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		15,711	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)		10,215	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)		3,999	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)		21,872,606	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)		21,872,606	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)		21,872,606	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)		1,392.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,567,328	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)		5,567,328	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN:14-0160	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/30/2021 1:02 pm	
			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	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	2,806,018	1,147	2,446.40	384	939,418	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					7,079,147	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					13,585,893	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					197,409	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					298,805	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					496,214	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					13,089,679	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					5,496	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,392.18	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					7,651,421	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020

Worksheet D-1

Date/Time Prepared:
7/30/2021 1:02 pm

		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	668,786	21,872,606	0.030576	7,651,421	233,950
91.00	Nursing School cost	0	21,872,606	0.000000	7,651,421	0
92.00	Allied health cost	0	21,872,606	0.000000	7,651,421	0
93.00	All other Medical Education	0	21,872,606	0.000000	7,651,421	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN:14-0160	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/30/2021 1:02 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		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		6,777,844		30.00
31.00	03100 INTENSIVE CARE UNIT		1,245,296		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.178822	10,867,407	1,943,331	50.00
50.01	05001 GI LAB	0.131840	1,256,851	165,703	50.01
50.02	05002 AMBULATORY CARE UNIT	2.315024	2,296	5,315	50.02
51.00	05100 RECOVERY ROOM	0.324176	300,506	97,417	51.00
53.00	05300 ANESTHESIOLOGY	0.048333	799,804	38,657	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.081469	5,970,936	486,446	54.00
60.00	06000 LABORATORY	0.144243	4,778,196	689,221	60.00
65.00	06500 RESPIRATORY THERAPY	0.168109	3,793,465	637,716	65.00
66.00	06600 PHYSICAL THERAPY	0.279538	1,303,676	364,427	66.00
69.00	06900 ELECTROCARDIOLOGY	0.058116	1,257,516	73,082	69.00
69.01	06901 CATH LAB	0.154266	1,715,504	264,644	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.006377	7,354	47	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.107284	10,098,240	1,083,380	73.00
74.00	07400 RENAL DIALYSIS	0.372510	290,011	108,032	74.00
76.00	03950 DIABETIC EDUCATION	1.447001	0	0	76.00
76.01	03480 CANCER CENTER	0.386606	2,971	1,149	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.181514	2,587	470	90.00
91.00	09100 EMERGENCY	0.195652	2,689,363	526,179	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.963137	616,663	593,931	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		45,753,346	7,079,147	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		45,753,346		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0160	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/30/2021 1:02 pm
		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)		969,377	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)		259,923	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)		84.98	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)		18.71	31.00
32.00	Sum of lines 30 and 31		22.08	32.00
33.00	Allowable disproportionate share percentage (see instructions)		7.56	33.00
34.00	Disproportionate share adjustment (see instructions)		169,521	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0160	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/30/2021 1:02 pm
		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)	0.000086499	0.000086436	
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	722,316	701,632	
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	540,750	176,850	
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	717,600		
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges, excluding 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)	10,116,421		
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	2,285,938		
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		10,243,559	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		700,618	
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		129,878	
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)		11,074,055	
60.00	Primary payer payments		0	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		11,074,055	
62.00	Deductibles billed to program beneficiaries		1,127,060	
63.00	Coinsurance billed to program beneficiaries		4,224	
64.00	Allowable bad debts (see instructions)		387,508	
65.00	Adjusted reimbursable bad debts (see instructions)		251,880	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		306,571	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		10,194,651	
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)		734	
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-2,171	
70.92	Bundled Model 1 discount amount (see instructions)		0	
70.93	HVBP payment adjustment amount (see instructions)		52,723	
70.94	HRR adjustment amount (see instructions)		-155,796	
70.95	Recovery of accelerated depreciation		0	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0160	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/30/2021 1:02 pm	
		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	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	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)			10,090,141	71.00
71.01	Sequestration adjustment (see instructions)			66,595	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			10,120,498	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)			-96,952	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			62,786	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)				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)		95,180	31,958	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		1.0056279287	1.0061961513	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		536	198	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.9832	0.9821	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-1,599	-572	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 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/30/2021 1:02 pm

		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	8,969,377	0	0	8,969,377	8,969,377
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	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	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	0	0	0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	259,923	0	0	259,923	259,923
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	0
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	0
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	0.0756	0.0756	0.0756	0.0756	0
11.00	Disproportionate share adjustment (see instructions)	34.00	169,521	0	0	169,521	169,521
11.01	Uncompensated care payments	36.00	717,600	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	10,116,421	237,096	0	9,879,325	10,116,421
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	10,285,938	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	10,243,559	237,096	0	10,006,463	10,243,559
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	700,618	0	0	700,618	700,618
17.00	Special add-on payments for new technologies	54.00	129,878	0	0	129,878	129,878
17.01	Net organ acquisition cost						

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
7/30/2021 1:02 pm

				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		
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	0	18.00
19.00	SUBTOTAL			237,096	0	10,836,959	11,074,055		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	697,456	0	0	697,456	697,456		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	3,162	0	0	3,162	3,162		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	700,618	0	0	700,618	700,618		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			0		0		28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				2,460	2,460		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 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/30/2021 1:02 pm

		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	8,969,377		8,969,377	8,969,377	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	259,923		259,923	259,923	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	0.0756	0.0756	0.0756		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	169,521	0	169,521	169,521	11.00
11.01	Uncompensated care payments	36.00	717,600	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	10,116,421	887,302	9,229,119	10,116,421	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	10,285,938	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	10,243,559	887,302	9,356,257	10,243,559	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	700,618	0	700,618	700,618	16.00
17.00	Special add-on payments for new technologies	54.00	129,878	0	129,878	129,878	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	10,186,753	11,074,055	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/30/2021 1:02 pm

		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	697,456	0	697,456	697,456	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	3,162	0	3,162	3,162	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	700,618	0	700,618	700,618	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	52,723	0	52,723	52,723	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	734	536	198	734	30.01
31.00	HRR adjustment (see instructions)	70.94	-155,796	0	-155,796	-155,796	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-2,171	-1,599	-572	-2,171	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 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/30/2021 1:02 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)	18,558	1.00	
2.00	Medical and other services reimbursed under OPPS (see instructions)	16,481,929	2.00	
3.00	OPPS payments	12,211,611	3.00	
4.00	Outlier payment (see instructions)	229,416	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	13,548,146	6.00	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	91.83	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)	18,558	11.00	
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges	80,920	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)	80,920	14.00	
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00	
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00	
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00	
18.00	Total customary charges (see instructions)	80,920	18.00	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	62,362	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)	18,558	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)	12,441,027	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)	2,363,847	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)	10,095,738	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)	10,095,738	30.00	
31.00	Primary payer payments	269	31.00	
32.00	Subtotal (line 30 minus line 31)	10,095,469	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)	662,997	34.00	
35.00	Adjusted reimbursable bad debts (see instructions)	430,948	35.00	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	555,577	36.00	
37.00	Subtotal (see instructions)	10,526,417	37.00	
38.00	MSP-LCC reconciliation amount from PS&R	1,291	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)	10,525,126	40.00	
40.01	Sequestration adjustment (see instructions)	69,466	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	10,577,663	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)	-122,003	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 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/30/2021 1:02 pm

		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		10,288,577		10,547,305	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	11/30/2020	30,358	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	11/30/2020	168,079		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)		-168,079		30,358	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)		10,120,498		10,577,663	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		96,952		122,003	6.02	
7.00	Total Medicare program liability (see instructions)		10,023,546		10,455,660	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 01/01/2020 To 12/31/2020	Worksheet E-1 Part II Date/Time Prepared: 7/30/2021 1:02 pm
		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 01/01/2020 To 12/31/2020		Worksheet G Date/Time Prepared: 7/30/2021 1:02 pm	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund		
		1.00	2.00	3.00	4.00		
CURRENT ASSETS							
1.00	Cash on hand in banks	63,597,536	0	0	0	1.00	
2.00	Temporary investments	8,750,138	0	0	0	2.00	
3.00	Notes receivable	0	0	0	0	3.00	
4.00	Accounts receivable	20,419,103	0	0	0	4.00	
5.00	Other receivable	367,913	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	3,653,911	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)	96,788,601	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	19,781,331	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)	19,781,331	0	0	0	30.00	
OTHER ASSETS							
31.00	Investments	5,774,931	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	2,365,483	0	0	0	34.00	
35.00	Total other assets (sum of lines 31-34)	8,140,414	0	0	0	35.00	
36.00	Total assets (sum of lines 11, 30, and 35)	124,710,346	0	0	0	36.00	
CURRENT LIABILITIES							
37.00	Accounts payable	327,818	0	0	0	37.00	
38.00	Salaries, wages, and fees payable	4,783,763	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	30,313,032	0	0	0	44.00	
45.00	Total current liabilities (sum of lines 37 thru 44)	35,424,613	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	4,918,632	0	0	0	49.00	
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,918,632	0	0	0	50.00	
51.00	Total liabilities (sum of lines 45 and 50)	40,343,245	0	0	0	51.00	
CAPITAL ACCOUNTS							
52.00	General fund balance	84,367,101	0	0	0	52.00	
53.00	Specific purpose fund	0	0	0	0	53.00	
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00	
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00	
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00	
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00	
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00	
59.00	Total fund balances (sum of lines 52 thru 58)	84,367,101	0	0	0	59.00	
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	124,710,346	0	0	0	60.00	

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020

Worksheet G-1

Date/Time Prepared:
7/30/2021 1:02 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		72,948,952		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		10,032,370				2.00
3.00	Total (sum of line 1 and line 2)		82,981,322		0		3.00
4.00	PRIOR PERIOD ADJ	1,385,779		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)		1,385,779		0		10.00
11.00	Subtotal (line 3 plus line 10)		84,367,101		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)		84,367,101		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 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/30/2021 1:02 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	38,015,164		38,015,164	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)	38,015,164		38,015,164	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,871,385		3,871,385	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)	3,871,385		3,871,385	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	41,886,549		41,886,549	17.00
18.00	Ancillary services	116,628,708	292,238,918	408,867,626	18.00
19.00	Outpatient services	9,269,502	53,975,460	63,244,962	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	8,000	7,147,414	7,155,414	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)	167,792,759	353,361,792	521,154,551	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		118,523,313		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)		118,523,313		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN:14-0160

Period:
From 01/01/2020
To 12/31/2020

Worksheet G-3

Date/Time Prepared:
7/30/2021 1:02 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	521,154,551	1.00
2.00	Less contractual allowances and discounts on patients' accounts	391,975,421	2.00
3.00	Net patient revenues (line 1 minus line 2)	129,179,130	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	118,523,313	4.00
5.00	Net income from service to patients (line 3 minus line 4)	10,655,817	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	59,201	6.00
7.00	Income from investments	699,146	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	7,066,432	24.00
24.01	MEDICAID ASSESSMENT REV	66,654	24.01
24.02	SALE OF ASSETS	3,061	24.02
24.03	OTHER NET	58,385	24.03
24.04	NET ASSETS RELEASED	292,708	24.04
24.05	OTHER (SPECIFY)	0	24.05
24.06	OTHER (SPECIFY)	0	24.06
24.50	COVID-19 PHE Funding	12,964,974	24.50
25.00	Total other income (sum of lines 6-24)	21,210,561	25.00
26.00	Total (line 5 plus line 25)	31,866,378	26.00
27.00	OTHER NON-OPERATING REVENUE	58,385	27.00
27.01	TRANSFER FROM AFFIL	21,775,623	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)	21,834,008	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	10,032,370	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN:14-0160

Period:

Worksheet 0

Hospice CCN: 14-1560

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/30/2021 1:02 pm

				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	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	6,361	6,361	0	6,361	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	85,281	85,281	0	85,281	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	85	85	0	85	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	56,792	56,792	0	56,792	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	10,120	0	10,120	0	10,120	13.00
14.00	PHARMACY*	0	186,536	186,536	0	186,536	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*		0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	223,591	0	223,591	0	223,591	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	9,121	0	9,121	0	9,121	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	544,468	824,112	1,368,580	0	1,368,580	28.00
29.00	LPN/LVN**	99,457		99,457	0	99,457	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**	156,006	0	156,006	0	156,006	33.00
34.00	SPIRITUAL COUNSELING**	11,815	0	11,815	0	11,815	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	34,540	34,540	0	34,540	38.00
39.00	PATIENT TRANSPORTATION**	0	17,845	17,845	0	17,845	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
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	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	1,054,578	1,211,552	2,266,130	0	2,266,130	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 01/01/2020
To 12/31/2020Date/Time Prepared:
7/30/2021 1:02 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		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	6,361	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	85,281	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	85	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	56,792	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	10,120	13.00
14.00	PHARMACY*	0	186,536	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	223,591	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	9,121	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	1,368,580	28.00
29.00	LPN/LVN**	0	99,457	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	156,006	33.00
34.00	SPIRITUAL COUNSELING**	0	11,815	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	34,540	38.00
39.00	PATIENT TRANSPORTATION**	0	17,845	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
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	0	2,266,130	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: From 01/01/2020 To 12/31/2020	Worksheet 0-2
	Hospice CCN: 14-1560	Date/Time Prepared: 7/30/2021 1:02 pm	

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	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	9,006	0	9,006	0	9,006	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	537,595	813,708	1,351,303	0	1,351,303	28.00
29.00	LPN/LVN	98,202	0	98,202	0	98,202	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	154,037	0	154,037	0	154,037	33.00
34.00	SPIRITUAL COUNSELING	11,665	0	11,665	0	11,665	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	34,104	34,104	0	34,104	38.00
39.00	PATIENT TRANSPORTATION	0	17,620	17,620	0	17,620	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 *	810,505	865,432	1,675,937	0	1,675,937	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	9,006	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	1,351,303	28.00
29.00	LPN/LVN	0	98,202	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	154,037	33.00
34.00	SPIRITUAL COUNSELING	0	11,665	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	34,104	38.00
39.00	PATIENT TRANSPORTATION	0	17,620	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	1,675,937	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 RESIDENT CARE		Provider CCN:14-0160	Period: From 01/01/2020 To 12/31/2020	Worksheet 0-3
		Hospice CCN: 14-1560		Date/Time Prepared: 7/30/2021 1:02 pm

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	Hospice I RECLASSIFICATIONS	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	96	0	96	0	96	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	5,739	8,687	14,426	0	14,426	28.00
29.00	LPN/LVN	1,048	0	1,048	0	1,048	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	1,644	0	1,644	0	1,644	33.00
34.00	SPIRITUAL COUNSELING	125	0	125	0	125	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	364	364	0	364	38.00
39.00	PATIENT TRANSPORTATION	0	188	188	0	188	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 *	8,652	9,239	17,891	0	17,891	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	96	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	14,426	28.00
29.00	LPN/LVN	0	1,048	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	1,644	33.00
34.00	SPIRITUAL COUNSELING	0	125	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	364	38.00
39.00	PATIENT TRANSPORTATION	0	188	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	17,891	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	Period: From 01/01/2020 To 12/31/2020	Worksheet 0-4
		Hospice CCN: 14-1560		Date/Time Prepared: 7/30/2021 1:02 pm

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	Hospice I RECLASSIFICATIONS	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	19	0	19	0	19	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	1,134	1,717	2,851	0	2,851	28.00
29.00	LPN/LVN	207	0	207	0	207	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	325	0	325	0	325	33.00
34.00	SPIRITUAL COUNSELING	25	0	25	0	25	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	72	72	0	72	38.00
39.00	PATIENT TRANSPORTATION	0	37	37	0	37	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 *	1,710	1,826	3,536	0	3,536	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	19	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	2,851	28.00
29.00	LPN/LVN	0	207	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	325	33.00
34.00	SPIRITUAL COUNSELING	0	25	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	72	38.00
39.00	PATIENT TRANSPORTATION	0	37	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	3,536	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

Period:

Worksheet 0-5

Hospice CCN: 14-1560

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/30/2021 1:02 pm

Descriptions		Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		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	16,546	16,546	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	6,361	289,836	296,197	3.00
4.00	ADMINISTRATIVE & GENERAL	85,281	644,921	730,202	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	85	11,661	11,746	10.00
11.00	MEDICAL RECORDS	0	45,659	45,659	11.00
12.00	STAFF TRANSPORTATION	56,792		56,792	12.00
13.00	VOLUNTEER SERVICE COORDINATION	10,120		10,120	13.00
14.00	PHARMACY	186,536	63,998	250,534	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	223,591	0	223,591	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	1,675,937		1,675,937	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	17,891		17,891	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	3,536		3,536	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	2,266,130	1,072,621	3,338,751	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN:14-0160

Period:

Worksheet 0-6

Hospice CCN: 14-1560

From 01/01/2020
To 12/31/2020Part I
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Descriptions		TOTAL EXPENSES		CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	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	16,546		16,546				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	296,197	0	0	296,197			3.00
4.00	ADMINISTRATIVE & GENERAL	730,202	0	0	0	730,202		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	11,746	0	0	0	11,746		10.00
11.00	MEDICAL RECORDS	45,659	0	0	0	45,659		11.00
12.00	STAFF TRANSPORTATION	56,792	0	0	0	56,792		12.00
13.00	VOLUNTEER SERVICE COORDINATION	10,120	0	0	0	10,120		13.00
14.00	PHARMACY	250,534	0	0	0	250,534		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0		15.00
16.00	OTHER GENERAL SERVICE	223,591	0	0	0	223,591		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	1,675,937			292,458	1,968,395		51.00
52.00	HOSPICE INPATIENT RESPITE CARE	17,891	0	9,307	3,122	30,320		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	3,536	0	7,239	617	11,392		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	0		99.00
100.00	TOTAL	3,338,751	0	16,546	296,197	3,338,751		100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN:14-0160

Period:

Worksheet 0-6

Hospice CCN: 14-1560

From 01/01/2020
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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	730,202						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	3,288	0			0		10.00
11.00	MEDICAL RECORDS	12,781	0			0		11.00
12.00	STAFF TRANSPORTATION	15,898	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	2,833	0			0		13.00
14.00	PHARMACY	70,131	0			0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0			0		15.00
16.00	OTHER GENERAL SERVICE	62,589	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	551,006						51.00
52.00	HOSPICE INPATIENT RESPITE CARE	8,487	0		0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	3,189	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	730,202	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

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Descriptions		Hospice I					
		NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	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	15,034				10.00
11.00	MEDICAL RECORDS	0		58,440			11.00
12.00	STAFF TRANSPORTATION	0			72,690		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0				12,953	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	14,845	57,702	71,773	12,789	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	158	616	766	137	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	31	122	151	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	0	0	0	0	0	99.00
100.00	TOTAL	0	15,034	58,440	72,690	12,953	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN:14-0160

Period:

Worksheet 0-6

Hospice CCN: 14-1560

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Descriptions		PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	Hospice I PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		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	320,665					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		286,180			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	316,617	0	282,567		3,275,694	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3,380	0	3,017	0	46,881	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	668	0	596	0	16,176	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	320,665	0	286,180	0	3,338,751	100.00

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

Provider CCN:14-0160

Period:

Worksheet 0-6

Hospice CCN: 14-1560

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
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Cost Center Descriptions		CAP REL BLDG & FIX (FIX (SQUARE FEET))	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Hospice I RECONCILIATION	ADMINISTRATIVE & 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		48				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	15,843			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-730,202	2,608,549	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	11,746	10.00
11.00	MEDICAL RECORDS	0	0	0	0	45,659	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	56,792	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	10,120	13.00
14.00	PHARMACY	0	0	0	0	250,534	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	223,591	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			15,643	0	1,968,395	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	27	167	0	30,320	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	21	33	0	11,392	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	16,546	296,197		730,202	100.00
101.00	UNIT COST MULTIPLIER	0.000000	344.708333	18.695765		0.279927	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 01/01/2020
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Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (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:

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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	15,843					10.00
11.00	MEDICAL RECORDS		15,843				11.00
12.00	STAFF TRANSPORTATION			15,843			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	15,843		13.00
14.00	PHARMACY			0	0	15,843	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	15,643	15,643	15,643	15,643	15,643	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	167	167	167	167	167	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	33	33	33	33	33	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			0	0	0	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)	15,034	58,440	72,690	12,953	320,665	100.00
101.00	UNIT COST MULTIPLIER	0.948936	3.688695	4.588146	0.817585	20.240169	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 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
7/30/2021 1:02 pm

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		15,843			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	15,643			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	167	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	33	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	286,180	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	18.063498	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE		Provider CCN:14-0160	Period: From 01/01/2020 To 12/31/2020	Worksheet 0-7
		Hospice CCN: 14-1560		Date/Time Prepared: 7/30/2021 1:02 pm

					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
	ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.279538	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	0.107284	0	214,023	0	4.00	
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00	
6.00	LABORATORY	60.00	0.144243	0	0	0	6.00	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.006377	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	1.447001	0	0	0	10.00	
10.01	CANCER CENTER	76.01	0.386606	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		
	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	22,961	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)							11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN:14-0160

Period:

Worksheet 0-8

Hospice CCN: 14-1560

From 01/01/2020
To 12/31/2020Date/Time Prepared:
7/30/2021 1:02 pm

		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)			3,298,655	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			15,643	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			210.87	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	14,719	118		9.00
10.00	Program cost (line 8 times line 9)	3,103,796	24,883		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)			46,881	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			167	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			280.72	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	136	0		14.00
15.00	Program cost (line 13 times line 14)	38,178	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)			16,176	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			33	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			490.18	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	20	0		19.00
20.00	Program cost (line 18 times line 19)	9,804	0		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			3,361,712	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			15,843	22.00
23.00	Average cost per diem (line 21 divided by line 22)			212.19	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN:14-0160	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 7/30/2021 1:02 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		697,456	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		3,162	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)		31.38	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)		700,618	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