

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND PROVIDER CCN:14-0160		Period: From 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/26/2022 5:03 pm
SETTLEMENT SUMMARY			

PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 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.		Date:5/26/2022 Time: 5:03 pm
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)
 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 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 01/01/2021 and ending 12/31/2021 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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	Michael C Clark	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Michael C Clark		2
3	Signatory Title	EVP AND CFO		3
4	Date	(Dated when report is electronic)		4

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	-102,572	-80,442	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	-102,572	-80,442	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 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 5:03 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)						01/01/2021	12/31/2021	
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	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
5/26/2022 5:03 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	
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.	1,332	931	15	18	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
				Urban/Rural 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.				01/01/2021	12/31/2021		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)				Y	Y		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)				with	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.				submit	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. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.				or "N"			56.00
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							57.00
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				N			58.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.				N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-0160		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 5:03 pm	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
5/26/2022 5:03 pm

			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		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	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 5:03 pm	
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N			80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N			81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N			85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N			87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-0160	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 5:03 pm
		V	XIX	
		1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR N Section §412.113(c). Enter "Y" for yes or "N" for no.			108.00
		Physical	Occupational	Speech
		1.00	2.00	3.00
				Respiratory
		1.00	2.00	3.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N
				N
				1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N
				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		
				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		
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		
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y		
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		
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		
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	0	0	364,211
				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		
119.00	DO NOT USE THIS LINE			
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		Y
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		
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		
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		
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.			
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.			
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.			
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.			
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.			

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 01/01/2021 To 12/31/2021	
				Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 5:03 pm	
		1.00		2.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00	
133.00	Removed and reserved			133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00	
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			140.00	
		1.00		2.00	
		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:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
		1.00		2.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y	
		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	
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	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N	
		Part A		Part B	
		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	
156.00	Subprovider - IPF	N		N	
157.00	Subprovider - IRF	N		N	
158.00	SUBPROVIDER	N		N	
159.00	SNF	N		N	
160.00	HOME HEALTH AGENCY	N		N	
161.00	CMHC	N		N	
		1.00			
Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			Enter N	
		Name		County	
		0		1.00	
		2.00		3.00	
		4.00		5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)			0.00	
		1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act					
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y	
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-0160	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 5:03 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)			171.00

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 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 5:03 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider 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 programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
				Date	
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	04/05/2022	Y	04/05/2022
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 01/01/2021 To 12/31/2021	
		Worksheet S-2 Part II		Date/Time Prepared: 5/26/2022 5:03 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	12/31/2021		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

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 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 5:03 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 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/26/2022 5:03 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	33,580	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		92	33,580	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		100	36,500	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		100				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/26/2022 5:03 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)	3,729	1,788	10,337			1.00
2.00 HMO and other (see instructions)	3,190	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)	3,729	1,788	10,337			7.00
8.00 INTENSIVE CARE UNIT	509	150	1,332			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		358	538			13.00
14.00 Total (see instructions)	4,238	2,296	12,207	0.00	514.30	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	17.97	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	532.27	27.00
28.00 Observation Bed Days		0	7,372			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	152			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 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/26/2022 5:03 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	939	618	2,699	1.00
2.00 HMO and other (see instructions)			661	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	939	618	2,699	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 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
5/26/2022 5:03 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	39,293,671	0	39,293,671	1,084,309.99	36.24
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		4,132,102	0	4,132,102	34,185.00	120.87
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)		1,141,981	13,996	1,155,977	37,238.00	31.04
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,063,336	0	2,063,336	19,099.76	108.03
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	46.25	129.73
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		5,136,601	0	5,136,601	131,080.00	39.19
14.02	Related organization salaries		0	0	0	0.00	0.00
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)		10,161,521	0	10,161,521		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		373,581	0	373,581		
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		342,951	0	342,951		
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)		1,941,712	0	1,941,712		
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 01/01/2021
To 12/31/2021Worksheet S-3
Part II
Date/Time Prepared:
5/26/2022 5:03 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	
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	3,207,496	-8,515	3,198,981	108,271.00	29.55	27.00
28.00	Administrative & General under contract (see inst.)		145,184	0	145,184	1,441.60	100.71	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	357,230	0	357,230	18,258.00	19.57	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)		969,584	0	969,584	66,628.00	14.55	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,207,243	0	1,207,243	64,967.24	18.58	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	721,078	0	721,078	15,667.00	46.03	38.00
39.00	Central Services and Supply	14.00	96,681	0	96,681	6,510.00	14.85	39.00
40.00	Pharmacy	15.00	1,129,772	0	1,129,772	27,647.00	40.86	40.00
41.00	Medical Records & Medical Records Library	16.00	1,160,846	0	1,160,846	39,283.00	29.55	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 01/01/2021
To 12/31/2021Worksheet S-3
Part III
Date/Time Prepared:
5/26/2022 5:03 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)	37,483,580	0	37,483,580	1,183,161.83	31.68	1.00
2.00	Excluded area salaries (see instructions)	1,141,981	13,996	1,155,977	37,238.00	31.04	2.00
3.00	Subtotal salaries (line 1 minus line 2)	36,341,599	-13,996	36,327,603	1,145,923.83	31.70	3.00
4.00	Subtotal other wages & related costs (see inst.)	7,205,937	0	7,205,937	150,226.01	47.97	4.00
5.00	Subtotal wage-related costs (see inst.)	12,103,233	0	12,103,233	0.00	33.32	5.00
6.00	Total (sum of lines 3 thru 5)	55,650,769	-13,996	55,636,773	1,296,149.84	42.92	6.00
7.00	Total overhead cost (see instructions)	8,995,114	-8,515	8,986,599	348,672.84	25.77	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part IV
Date/Time Prepared:
5/26/2022 5:03 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)	520,455	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	35,763	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)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	7,219,385	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	11,028	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	37,361	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)	91,405	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	247,811	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	2,757,422	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	-42,577	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)	10,878,053	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 01/01/2021
To 12/31/2021Worksheet S-3
Part V
Date/Time Prepared:
5/26/2022 5:03 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	2,063,336	10,874,419	1.00
2.00	Hospital	2,063,336	10,874,419	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 01/01/2021 To 12/31/2021	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 5/26/2022 5:03 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	12,151	72	660	12,883	11.00
12.00	Hospice Inpatient Respite Care	220	0	39	259	12.00
13.00	Hospice General Inpatient Care	1	0	2	3	13.00
14.00	Total Hospice Days	12,372	72	701	13,145	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 01/01/2021 To 12/31/2021	Worksheet S-10 Date/Time Prepared: 5/26/2022 5:03 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)			0.198146	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			8,989,964	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			3,464,588	5.00
6.00	Medicaid charges			94,004,502	6.00
7.00	Medicaid cost (line 1 times line 6)			18,626,616	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)			< 6,172,064	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 8,612,722,064 and 16)			8,612,722,064	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)	418,889	845,797	1,264,686	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	83,001	845,797	928,798	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)	83,001	845,797	928,798	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)			9,382,042	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			532,719	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			819,567	27.01
28.00	Non-Medicare bad debt expense (see instructions)			8,562,475	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,983,468	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,912,266	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			9,084,330	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021

Worksheet A

Date/Time Prepared:
5/26/2022 5:03 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	1,341,610	1,341,610	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,180,056	4,180,056	-1,341,610	2,838,446	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,874,419	10,874,419	0	10,874,419	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,207,496	20,976,616	24,184,112	-9,131	24,174,981	5.00
7.00	00700	OPERATION OF PLANT	357,230	2,894,743	3,251,973	0	3,251,973	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	330,225	330,225	0	330,225	8.00
9.00	00900	HOUSEKEEPING	0	1,940,667	1,940,667	0	1,940,667	9.00
10.00	01000	DIETARY	0	2,065,112	2,065,112	-875,987	1,189,125	10.00
11.00	01100	CAFETERIA	0	0	0	875,987	875,987	11.00
13.00	01300	NURSING ADMINISTRATION	721,078	177,083	898,161	0	898,161	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	96,681	432,540	529,221	0	529,221	14.00
15.00	01500	PHARMACY	1,129,772	5,083,828	6,213,600	-4,008,081	2,205,519	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,160,846	659,653	1,820,499	0	1,820,499	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,114,609	3,209,173	15,323,782	-6,803	15,316,979	30.00
31.00	03100	INTENSIVE CARE UNIT	1,465,632	282,482	1,748,114	0	1,748,114	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,973,391	5,860,440	7,833,831	0	7,833,831	50.00
50.01	05001	GI LAB	905,104	801,802	1,706,906	0	1,706,906	50.01
50.02	05002	AMBULATORY CARE UNIT	1,467,075	1,038,092	2,505,167	0	2,505,167	50.02
51.00	05100	RECOVERY ROOM	473,471	16,052	489,523	0	489,523	51.00
53.00	05300	ANESTHESIOLOGY	0	1,046,561	1,046,561	0	1,046,561	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,542,911	4,920,551	7,463,462	0	7,463,462	54.00
60.00	06000	LABORATORY	1,435,098	4,821,488	6,256,586	0	6,256,586	60.00
65.00	06500	RESPIRATORY THERAPY	932,567	291,687	1,224,254	0	1,224,254	65.00
66.00	06600	PHYSICAL THERAPY	2,486,181	122,639	2,608,820	0	2,608,820	66.00
69.00	06900	ELECTROCARDIOLOGY	231,690	321,282	552,972	0	552,972	69.00
69.01	06901	CATH LAB	445,915	606,320	1,052,235	0	1,052,235	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,008,081	4,008,081	73.00
74.00	07400	RENAL DIALYSIS	0	153,141	153,141	0	153,141	74.00
76.00	03950	DIABETIC EDUCATION	57	75,555	75,612	0	75,612	76.00
76.01	03480	CANCER CENTER	1,675,608	8,226,530	9,902,138	0	9,902,138	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	7,586	1,208,666	1,216,252	0	1,216,252	90.00
91.00	09100	EMERGENCY	3,321,692	6,258,101	9,579,793	0	9,579,793	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	1,141,981	936,593	2,078,574	0	2,078,574	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,293,671	89,812,097	129,105,768	-15,934	129,089,834	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	0	0	0	9,131	9,131	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	0	0	0	6,803	6,803	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	39,293,671	89,812,097	129,105,768	0	129,105,768	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021

Worksheet A

Date/Time Prepared:
5/26/2022 5:03 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	1,341,610	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	2,838,446	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,874,419	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,265,506	18,909,475	5.00
7.00	00700	OPERATION OF PLANT	0	3,251,973	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	330,225	8.00
9.00	00900	HOUSEKEEPING	0	1,940,667	9.00
10.00	01000	DIETARY	-12,945	1,176,180	10.00
11.00	01100	CAFETERIA	-893	875,094	11.00
13.00	01300	NURSING ADMINISTRATION	-30,000	868,161	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	529,221	14.00
15.00	01500	PHARMACY	0	2,205,519	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-406	1,820,093	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-4,744,324	10,572,655	30.00
31.00	03100	INTENSIVE CARE UNIT	-116,915	1,631,199	31.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-332,398	7,501,433	50.00
50.01	05001	GI LAB	0	1,706,906	50.01
50.02	05002	AMBULATORY CARE UNIT	0	2,505,167	50.02
51.00	05100	RECOVERY ROOM	0	489,523	51.00
53.00	05300	ANESTHESIOLOGY	-914,002	132,559	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,239,407	4,224,055	54.00
60.00	06000	LABORATORY	-518,173	5,738,413	60.00
65.00	06500	RESPIRATORY THERAPY	-82,946	1,141,308	65.00
66.00	06600	PHYSICAL THERAPY	-1,759	2,607,061	66.00
69.00	06900	ELECTROCARDIOLOGY	-215,377	337,595	69.00
69.01	06901	CATH LAB	0	1,052,235	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,008,081	73.00
74.00	07400	RENAL DIALYSIS	0	153,141	74.00
76.00	03950	DIABETIC EDUCATION	0	75,612	76.00
76.01	03480	CANCER CENTER	-1,730,168	8,171,970	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	1,216,252	90.00
91.00	09100	EMERGENCY	-4,893,403	4,686,390	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	2,078,574	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-22,098,622	106,991,212	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	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	9,131	192.03
192.04	19204	SMART STEPS	0	0	192.04
192.05	19205	RESPITE CARE	0	6,803	192.05
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-22,098,622	107,007,146	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
1.00	A - CHARGEABLE DRUGS				1.00
	DRUGS CHARGED TO PATIENTS	73.00	0	4,008,081	
	TOTALS		0	4,008,081	
1.00	B - SHARED DIETARY EXPENSES				1.00
	CAFETERIA	11.00	0	875,987	
	TOTALS		0	875,987	
1.00	C - RESPITE CARE				1.00
	RESPITE CARE	192.05	5,481	1,322	
	TOTALS		5,481	1,322	
1.00	D - NON PATIENT VOLUNTEER ADMIN				1.00
	NA VOLUNTEER SERVICES	192.03	8,515	616	
	TOTALS		8,515	616	
1.00	E - BUILDING DEPRECIATION				1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	1,341,610	
	TOTALS		0	1,341,610	
500.00	Grand Total: Increases		13,996	6,227,616	500.00

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - CHARGEABLE DRUGS						1.00
	PHARMACY	15.00	0	4,008,081	0		
	TOTALS		0	4,008,081			
1.00	B - SHARED DIETARY EXPENSES						1.00
	DIETARY	10.00	0	875,987	0		
	TOTALS		0	875,987			
1.00	C - RESPITE CARE						1.00
	ADULTS & PEDIATRICS	30.00	5,481	1,322	0		
	TOTALS		5,481	1,322			
1.00	D - NON PATIENT VOLUNTEER ADMIN						1.00
	ADMINISTRATIVE & GENERAL	5.00	8,515	616	0		
	TOTALS		8,515	616			
1.00	E - BUILDING DEPRECIATION						1.00
	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,341,610	9		
	TOTALS		0	1,341,610			
500.00	Grand Total: Decreases			13,996	6,227,616		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part I
Date/Time Prepared:
5/26/2022 5:03 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	59,266	0	59,266	0	2.00
3.00	Buildings and Fixtures	53,118,137	3,012,946	0	3,012,946	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,740,517	8,222	0	8,222	0	5.00
6.00	Movable Equipment	36,875,484	0	0	0	5,809,366	6.00
7.00	HIT designated Assets	3,246,690	5,155,767	0	5,155,767	0	7.00
8.00	Subtotal (sum of lines 1-7)	98,874,973	8,236,201	0	8,236,201	5,809,366	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	98,874,973	8,236,201	0	8,236,201	5,809,366	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	2,008,466	0				2.00
3.00	Buildings and Fixtures	56,131,083	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	2,748,739	0				5.00
6.00	Movable Equipment	31,066,118	0				6.00
7.00	HIT designated Assets	8,402,457	0				7.00
8.00	Subtotal (sum of lines 1-7)	101,301,808	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	101,301,808	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part II
Date/Time Prepared:
5/26/2022 5:03 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	4,180,056	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,180,056	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	4,180,056				2.00
3.00	Total (sum of lines 1-2)	0	4,180,056				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part III
Date/Time Prepared:
5/26/2022 5:03 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	70,235,690	0	70,235,690	0.693331	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	31,066,118	0	31,066,118	0.306669	0	2.00
3.00	Total (sum of lines 1-2)	101,301,808	0	101,301,808	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	1,341,610	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,838,446	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,180,056	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	1,341,610	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,838,446	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	4,180,056	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-8

Date/Time Prepared:
5/26/2022 5:03 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	-17,134,928				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	368,447				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 01/01/2021
To 12/31/2021

Worksheet A-8

Date/Time Prepared:
5/26/2022 5:03 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
Cost Center Description			Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.
			1.00	2.00	3.00	4.00	5.00
33.00	TRADE, QUANTITY AND TIME DISCOUNTS	B		-11,668	ADMINISTRATIVE & GENERAL	5.00	0 33.00
33.01	SALE OF MEDICAL RECORDS & ABSTRACTS	B		-406	MEDICAL RECORDS & LIBRARY	16.00	0 33.01
33.02	VENDING MACHINES	B		-893	CAFETERIA	11.00	0 33.02
33.03	PHYSICIAN COLLECTIONS EXPENSES	A		-81,030	ADMINISTRATIVE & GENERAL	5.00	0 33.03
33.04	DIETARY CONSULTING	B		-433	DIETARY	10.00	0 33.04
33.05	TELEPHONE CAPITAL COSTS	A		-56,629	ADMINISTRATIVE & GENERAL	5.00	0 33.05
33.06	TV CAPITAL COSTS	A		-12,720	ADMINISTRATIVE & GENERAL	5.00	0 33.06
33.07	ASSOC LOBBYING FEES	A		-28,625	ADMINISTRATIVE & GENERAL	5.00	0 33.07
33.08	MEALS ON WHEELS	B		-12,512	DIETARY	10.00	0 33.08
33.09	OTHER REVENUE MISC	B		-5,996	ADMINISTRATIVE & GENERAL	5.00	0 33.09
33.10	OB MISC INCOME	B		-62	ADULTS & PEDIATRICS	30.00	0 33.10
33.11	RENTAL INCOME	B		-21,525	ADMINISTRATIVE & GENERAL	5.00	0 33.11
33.12	RADIOLOGY MED RECORD REVENUE	B		-35	RADIOLOGY-DIAGNOSTIC	54.00	0 33.12
33.13	PT, OT, SPORTS MED MISC INCOME	B		-1,759	PHYSICAL THERAPY	66.00	0 33.13
33.14	PROVIDER TAX COST	A		-5,097,848	ADMINISTRATIVE & GENERAL	5.00	0 33.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			-22,098,622			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 01/01/2021
To 12/31/2021

Worksheet A-8-1

Date/Time Prepared:
5/26/2022 5:03 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	13,863,205	13,494,758	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.			13,863,205	13,494,758	5.00

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

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

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that 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 01/01/2021
To 12/31/2021

Worksheet A-8-1

Date/Time Prepared:
5/26/2022 5:03 pm

	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	368,447	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	368,447			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 01/01/2021
To 12/31/2021

Worksheet A-8-2

Date/Time Prepared:
5/26/2022 5:03 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	1,163,966	1,163,966	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	116,915	116,915	0	0	0	2.00
3.00	50.00	OPERATING ROOM	57,898	57,898	0	0	0	3.00
4.00	13.00	NURSING ADMINISTRATION	30,000	30,000	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	3,239,372	3,239,372	0	0	0	5.00
6.00	60.00	LABORATORY	518,173	518,173	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	215,377	215,377	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	82,946	82,946	0	0	0	8.00
9.00	91.00	EMERGENCY	4,893,403	4,893,403	0	0	0	9.00
10.00	76.01	CANCER CENTER	1,730,168	1,730,168	0	0	0	10.00
11.00	30.00	ADULTS & PEDIATRICS	3,066,448	3,066,448	0	0	0	11.00
12.00	5.00	ADMINISTRATIVE & GENERAL	321,871	315,871	6,000	179,000	46	12.00
13.00	30.00	ADULTS & PEDIATRICS	513,848	513,848	0	0	0	13.00
14.00	53.00	ANESTHESIOLOGY	914,002	914,002	0	0	0	14.00
15.00	50.00	OPERATING ROOM	274,500	274,500	0	0	0	15.00
200.00			17,138,887	17,132,887	6,000		46	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	76.01	CANCER CENTER	0	0	0	0	0	10.00
11.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	11.00
12.00	5.00	ADMINISTRATIVE & GENERAL	3,959	198	0	0	0	12.00
13.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	13.00
14.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	14.00
15.00	50.00	OPERATING ROOM	0	0	0	0	0	15.00
200.00			3,959	198	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,163,966		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	116,915		2.00
3.00	50.00	OPERATING ROOM	0	0	0	57,898		3.00
4.00	13.00	NURSING ADMINISTRATION	0	0	0	30,000		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	3,239,372		5.00
6.00	60.00	LABORATORY	0	0	0	518,173		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	215,377		7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	82,946		8.00
9.00	91.00	EMERGENCY	0	0	0	4,893,403		9.00
10.00	76.01	CANCER CENTER	0	0	0	1,730,168		10.00
11.00	30.00	ADULTS & PEDIATRICS	0	0	0	3,066,448		11.00
12.00	5.00	ADMINISTRATIVE & GENERAL	0	3,959	2,041	317,912		12.00
13.00	30.00	ADULTS & PEDIATRICS	0	0	0	513,848		13.00
14.00	53.00	ANESTHESIOLOGY	0	0	0	914,002		14.00
15.00	50.00	OPERATING ROOM	0	0	0	274,500		15.00
200.00			0	3,959	2,041	17,134,928		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/26/2022 5:03 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	1,341,610	1,341,610			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,838,446		2,838,446		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,874,419	8,165	0	10,882,584	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,909,475	292,047	117,134	885,974	5.00
7.00	00700	OPERATION OF PLANT	3,251,973	146,679	32,866	98,937	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	330,225	9,828	0	0	8.00
9.00	00900	HOUSEKEEPING	1,940,667	21,562	0	0	9.00
10.00	01000	DIETARY	1,176,180	48,533	8,831	0	10.00
11.00	01100	CAFETERIA	875,094	41,422	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	868,161	1,567	14,894	199,706	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	529,221	3,747	11	26,776	14.00
15.00	01500	PHARMACY	2,205,519	10,189	331,021	312,896	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,820,093	2,899	0	321,502	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,572,655	239,537	187,065	3,353,689	30.00
31.00	03100	INTENSIVE CARE UNIT	1,631,199	18,115	61,083	405,914	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,501,433	90,804	255,572	546,541	50.00
50.01	05001	GI LAB	1,706,906	29,291	88,302	250,673	50.01
50.02	05002	AMBULATORY CARE UNIT	2,505,167	38,066	15,700	406,314	50.02
51.00	05100	RECOVERY ROOM	489,523	7,003	10,210	131,130	51.00
53.00	05300	ANESTHESIOLOGY	132,559	3,612	45,518	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,224,055	73,446	652,305	704,272	54.00
60.00	06000	LABORATORY	5,738,413	37,200	279,551	397,458	60.00
65.00	06500	RESPIRATORY THERAPY	1,141,308	30,998	88,271	258,279	65.00
66.00	06600	PHYSICAL THERAPY	2,607,061	65,508	123,561	688,560	66.00
69.00	06900	ELECTROCARDIOLOGY	337,595	7,412	44,780	64,168	69.00
69.01	06901	CATH LAB	1,052,235	2,611	70,171	123,498	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,008,081	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	153,141	1,293	0	0	74.00
76.00	03950	DIABETIC EDUCATION	75,612	1,293	179	16	76.00
76.01	03480	CANCER CENTER	8,171,970	34,819	214,102	464,068	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,216,252	12,317	10,225	2,101	90.00
91.00	09100	EMERGENCY	4,686,390	57,512	172,808	919,959	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	2,078,574	0	14,286	316,277	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	106,991,212	1,337,475	2,838,446	10,878,708	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,330	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	805	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	9,131	0	0	2,358	192.03
192.04	19204	SMART STEPS	0	0	0	0	192.04
192.05	19205	RESPIRE CARE	6,803	0	0	1,518	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)	107,007,146	1,341,610	2,838,446	10,882,584	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/26/2022 5:03 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	20,204,630				5.00
7.00	00700	OPERATION OF PLANT	821,766	4,352,221			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	79,152	47,805	467,010		8.00
9.00	00900	HOUSEKEEPING	456,738	104,884	0	2,523,851	9.00
10.00	01000	DIETARY	287,126	236,083	0	141,882	1,898,635
11.00	01100	CAFETERIA	213,333	201,489	0	121,092	0
13.00	01300	NURSING ADMINISTRATION	252,394	7,622	0	4,581	0
14.00	01400	CENTRAL SERVICES & SUPPLY	130,291	18,229	0	10,955	0
15.00	01500	PHARMACY	665,621	49,562	0	29,786	0
16.00	01600	MEDICAL RECORDS & LIBRARY	499,163	14,100	0	8,474	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,340,906	1,165,192	120,311	700,261	1,806,283
31.00	03100	INTENSIVE CARE UNIT	492,603	88,116	24,256	52,956	92,352
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,953,911	441,701	33,958	265,455	0
50.01	05001	GI LAB	483,027	142,484	24,256	85,631	0
50.02	05002	AMBULATORY CARE UNIT	690,206	185,166	24,256	111,282	0
51.00	05100	RECOVERY ROOM	148,473	34,065	14,554	20,472	0
53.00	05300	ANESTHESIOLOGY	42,291	17,572	0	10,561	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,316,071	357,269	86,027	214,713	0
60.00	06000	LABORATORY	1,501,945	180,953	0	108,750	0
65.00	06500	RESPIRATORY THERAPY	353,537	150,783	4,852	90,618	0
66.00	06600	PHYSICAL THERAPY	811,114	318,652	29,107	191,505	0
69.00	06900	ELECTROCARDIOLOGY	105,665	36,055	0	21,668	0
69.01	06901	CATH LAB	290,611	12,703	24,256	7,634	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	932,941	0	0	0	0
74.00	07400	RENAL DIALYSIS	35,947	6,288	0	3,779	0
76.00	03950	DIABETIC EDUCATION	17,946	6,288	0	3,779	0
76.01	03480	CANCER CENTER	2,068,107	169,372	0	101,790	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	288,837	59,915	0	36,008	0
91.00	09100	EMERGENCY	1,358,572	279,760	81,177	168,131	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	560,763	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,199,057	4,332,108	467,010	2,511,763	1,898,635
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	775	16,196	0	9,734	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	187	3,917	0	2,354	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	2,674	0	0	0	0
192.04	19204	SMART STEPS	0	0	0	0	0
192.05	19205	RESPIRE CARE	1,937	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)	20,204,630	4,352,221	467,010	2,523,851	1,898,635

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/26/2022 5:03 pm

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	1,452,430					11.00
13.00	01300	NURSING ADMINISTRATION	22,714	1,371,639				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,829	0	729,059			14.00
15.00	01500	PHARMACY	41,538	0	12,652	3,658,784		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	58,799	0	11	0	2,725,041	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	438,297	930,225	143,762	1,569	188,183	30.00
31.00	03100	INTENSIVE CARE UNIT	47,129	118,964	44,131	1,090	22,644	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	84,916	0	39,521	13,681	390,037	50.00
50.01	05001	GI LAB	35,356	0	95,376	195	101,863	50.01
50.02	05002	AMBULATORY CARE UNIT	59,702	0	38,414	284,382	25,428	50.02
51.00	05100	RECOVERY ROOM	15,907	0	1,090	199	14,768	51.00
53.00	05300	ANESTHESIOLOGY	0	0	31,073	3,650	44,387	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	140,763	0	58,093	2,453	545,354	54.00
60.00	06000	LABORATORY	78,248	0	37,324	483	316,859	60.00
65.00	06500	RESPIRATORY THERAPY	44,038	0	34,206	2,090	75,065	65.00
66.00	06600	PHYSICAL THERAPY	108,290	0	10,551	24	96,844	66.00
69.00	06900	ELECTROCARDIOLOGY	8,648	0	838	0	51,029	69.00
69.01	06901	CATH LAB	17,851	0	506	54	59,782	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	127	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,279,943	337,259	73.00
74.00	07400	RENAL DIALYSIS	0	0	12	0	3,485	74.00
76.00	03950	DIABETIC EDUCATION	0	0	700	0	0	76.00
76.01	03480	CANCER CENTER	48,275	0	24,636	2,015,756	156,030	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	313	0	31,792	4,962	32,001	90.00
91.00	09100	EMERGENCY	135,900	322,450	114,478	2,159	233,669	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	55,083	0	9,893	46,094	30,227	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,451,596	1,371,639	729,059	3,658,784	2,725,041	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	556	0	0	0	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	278	0	0	0	0	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,452,430	1,371,639	729,059	3,658,784	2,725,041	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/26/2022 5:03 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	23,187,935	0	23,187,935	30.00
31.00	03100	INTENSIVE CARE UNIT	3,100,552	0	3,100,552	31.00
43.00	04300	NURSERY	0	0	0	43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	11,617,530	0	11,617,530	50.00
50.01	05001	GI LAB	3,043,360	0	3,043,360	50.01
50.02	05002	AMBULATORY CARE UNIT	4,384,083	0	4,384,083	50.02
51.00	05100	RECOVERY ROOM	887,394	0	887,394	51.00
53.00	05300	ANESTHESIOLOGY	331,223	0	331,223	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,374,821	0	8,374,821	54.00
60.00	06000	LABORATORY	8,677,184	0	8,677,184	60.00
65.00	06500	RESPIRATORY THERAPY	2,274,045	0	2,274,045	65.00
66.00	06600	PHYSICAL THERAPY	5,050,777	0	5,050,777	66.00
69.00	06900	ELECTROCARDIOLOGY	677,858	0	677,858	69.00
69.01	06901	CATH LAB	1,661,912	0	1,661,912	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	127	0	127	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,558,224	0	6,558,224	73.00
74.00	07400	RENAL DIALYSIS	203,945	0	203,945	74.00
76.00	03950	DIABETIC EDUCATION	105,813	0	105,813	76.00
76.01	03480	CANCER CENTER	13,468,925	0	13,468,925	76.01
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,694,723	0	1,694,723	90.00
91.00	09100	EMERGENCY	8,532,965	0	8,532,965	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	3,111,197	0	3,111,197	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	106,944,593	0	106,944,593	118.00
	NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	30,035	0	30,035	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,263	0	7,263	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	14,719	0	14,719	192.03
192.04	19204	SMART STEPS	0	0	0	192.04
192.05	19205	RESPIRE CARE	10,536	0	10,536	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)	107,007,146	0	107,007,146	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/26/2022 5:03 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,165	0	8,165	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	292,047	117,134	409,181	5.00
7.00	00700	OPERATION OF PLANT	0	146,679	32,866	179,545	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,828	0	9,828	8.00
9.00	00900	HOUSEKEEPING	0	21,562	0	21,562	9.00
10.00	01000	DIETARY	0	48,533	8,831	57,364	10.00
11.00	01100	CAFETERIA	0	41,422	0	41,422	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,567	14,894	16,461	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,747	11	3,758	14.00
15.00	01500	PHARMACY	0	10,189	331,021	341,210	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,899	0	2,899	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	239,537	187,065	426,602	30.00
31.00	03100	INTENSIVE CARE UNIT	0	18,115	61,083	79,198	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	90,804	255,572	346,376	50.00
50.01	05001	GI LAB	0	29,291	88,302	117,593	50.01
50.02	05002	AMBULATORY CARE UNIT	0	38,066	15,700	53,766	50.02
51.00	05100	RECOVERY ROOM	0	7,003	10,210	17,213	51.00
53.00	05300	ANESTHESIOLOGY	0	3,612	45,518	49,130	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	73,446	652,305	725,751	54.00
60.00	06000	LABORATORY	0	37,200	279,551	316,751	60.00
65.00	06500	RESPIRATORY THERAPY	0	30,998	88,271	119,269	65.00
66.00	06600	PHYSICAL THERAPY	0	65,508	123,561	189,069	66.00
69.00	06900	ELECTROCARDIOLOGY	0	7,412	44,780	52,192	69.00
69.01	06901	CATH LAB	0	2,611	70,171	72,782	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	1,293	0	1,293	74.00
76.00	03950	DIABETIC EDUCATION	0	1,293	179	1,472	76.00
76.01	03480	CANCER CENTER	0	34,819	214,102	248,921	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	12,317	10,225	22,542	90.00
91.00	09100	EMERGENCY	0	57,512	172,808	230,320	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	14,286	14,286	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,337,475	2,838,446	4,175,921	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,330	0	3,330	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	805	0	805	192.00
192.01	19201	JANE ADDAMS BLDG	0	0	0	0	192.01
192.02	19202	SENIOR PROGRAM	0	0	0	0	192.02
192.03	19203	NA VOLUNTEER SERVICES	0	0	0	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	192.04
192.05	19205	RESPIRE CARE	0	0	0	0	192.05
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,341,610	2,838,446	4,180,056	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/26/2022 5:03 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	409,846				5.00
7.00	00700	OPERATION OF PLANT	16,671	196,290			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,606	2,156	13,590		8.00
9.00	00900	HOUSEKEEPING	9,266	4,730	0	35,558	9.00
10.00	01000	DIETARY	5,825	10,648	0	1,999	75,836
11.00	01100	CAFETERIA	4,328	9,087	0	1,706	0
13.00	01300	NURSING ADMINISTRATION	5,120	344	0	65	0
14.00	01400	CENTRAL SERVICES & SUPPLY	2,643	822	0	154	0
15.00	01500	PHARMACY	13,503	2,235	0	420	0
16.00	01600	MEDICAL RECORDS & LIBRARY	10,126	636	0	119	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	67,738	52,553	3,501	9,867	72,147
31.00	03100	INTENSIVE CARE UNIT	9,993	3,974	706	746	3,689
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	39,638	19,921	988	3,740	0
50.01	05001	GI LAB	9,799	6,426	706	1,206	0
50.02	05002	AMBULATORY CARE UNIT	14,002	8,351	706	1,568	0
51.00	05100	RECOVERY ROOM	3,012	1,536	424	288	0
53.00	05300	ANESTHESIOLOGY	858	793	0	149	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,699	16,113	2,503	3,025	0
60.00	06000	LABORATORY	30,469	8,161	0	1,532	0
65.00	06500	RESPIRATORY THERAPY	7,172	6,800	141	1,277	0
66.00	06600	PHYSICAL THERAPY	16,455	14,372	847	2,698	0
69.00	06900	ELECTROCARDIOLOGY	2,144	1,626	0	305	0
69.01	06901	CATH LAB	5,895	573	706	108	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	18,926	0	0	0	0
74.00	07400	RENAL DIALYSIS	729	284	0	53	0
76.00	03950	DIABETIC EDUCATION	364	284	0	53	0
76.01	03480	CANCER CENTER	41,955	7,639	0	1,434	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	5,860	2,702	0	507	0
91.00	09100	EMERGENCY	27,561	12,617	2,362	2,369	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	11,376	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	409,733	195,383	13,590	35,388	75,836
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16	730	0	137	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4	177	0	33	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	54	0	0	0	0
192.04	19204	SMART STEPS	0	0	0	0	0
192.05	19205	RESPIRE CARE	39	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)	409,846	196,290	13,590	35,558	75,836

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/26/2022 5:03 pm

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	56,543					11.00
13.00	01300	NURSING ADMINISTRATION	884	23,024				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	383	0	7,780			14.00
15.00	01500	PHARMACY	1,617	0	135	359,355		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,289	0	0	0	16,310	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,063	15,614	1,533	154	1,118	30.00
31.00	03100	INTENSIVE CARE UNIT	1,835	1,997	471	107	135	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,306	0	422	1,344	2,318	50.00
50.01	05001	GI LAB	1,376	0	1,018	19	605	50.01
50.02	05002	AMBULATORY CARE UNIT	2,324	0	410	27,931	151	50.02
51.00	05100	RECOVERY ROOM	619	0	12	20	88	51.00
53.00	05300	ANESTHESIOLOGY	0	0	332	358	264	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,480	0	620	241	3,358	54.00
60.00	06000	LABORATORY	3,046	0	398	47	1,883	60.00
65.00	06500	RESPIRATORY THERAPY	1,714	0	365	205	446	65.00
66.00	06600	PHYSICAL THERAPY	4,216	0	113	2	575	66.00
69.00	06900	ELECTROCARDIOLOGY	337	0	9	0	303	69.00
69.01	06901	CATH LAB	695	0	5	5	355	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	1	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	125,714	2,004	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	21	74.00
76.00	03950	DIABETIC EDUCATION	0	0	7	0	0	76.00
76.01	03480	CANCER CENTER	1,879	0	263	197,982	927	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	12	0	339	487	190	90.00
91.00	09100	EMERGENCY	5,291	5,413	1,222	212	1,388	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	2,144	0	106	4,527	180	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,510	23,024	7,780	359,355	16,310	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	22	0	0	0	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	0	192.04
192.05	19205	RESPITE CARE	11	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)	56,543	23,024	7,780	359,355	16,310	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part II
Date/Time Prepared:
5/26/2022 5:03 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	670,401	0	670,401		30.00
31.00	03100	INTENSIVE CARE UNIT	103,156	0	103,156		31.00
43.00	04300	NURSERY	0	0	0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	418,463	0	418,463		50.00
50.01	05001	GI LAB	138,936	0	138,936		50.01
50.02	05002	AMBULATORY CARE UNIT	109,514	0	109,514		50.02
51.00	05100	RECOVERY ROOM	23,310	0	23,310		51.00
53.00	05300	ANESTHESIOLOGY	51,884	0	51,884		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	784,319	0	784,319		54.00
60.00	06000	LABORATORY	362,586	0	362,586		60.00
65.00	06500	RESPIRATORY THERAPY	137,583	0	137,583		65.00
66.00	06600	PHYSICAL THERAPY	228,864	0	228,864		66.00
69.00	06900	ELECTROCARDIOLOGY	56,964	0	56,964		69.00
69.01	06901	CATH LAB	81,217	0	81,217		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1	0	1		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	146,644	0	146,644		73.00
74.00	07400	RENAL DIALYSIS	2,380	0	2,380		74.00
76.00	03950	DIABETIC EDUCATION	2,180	0	2,180		76.00
76.01	03480	CANCER CENTER	501,349	0	501,349		76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	32,641	0	32,641		90.00
91.00	09100	EMERGENCY	289,446	0	289,446		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	32,857	0	32,857		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,174,695	0	4,174,695		118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,213	0	4,213		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,019	0	1,019		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	78	0	78		192.03
192.04	19204	SMART STEPS	0	0	0		192.04
192.05	19205	RESPIRE CARE	51	0	51		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)	4,180,056	0	4,180,056		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
5/26/2022 5:03 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		2,838,444			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,876	0	39,293,671		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	67,101	117,134	3,198,981	-20,204,630	5.00
7.00	00700	OPERATION OF PLANT	33,701	32,866	357,230	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	14,894	721,078	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	861	11	96,681	0	14.00
15.00	01500	PHARMACY	2,341	331,021	1,129,772	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	666	0	1,160,846	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	55,036	187,065	12,109,128	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,162	61,083	1,465,632	0	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,863	255,572	1,973,391	0	50.00
50.01	05001	GI LAB	6,730	88,302	905,104	0	50.01
50.02	05002	AMBULATORY CARE UNIT	8,746	15,700	1,467,075	0	50.02
51.00	05100	RECOVERY ROOM	1,609	10,210	473,471	0	51.00
53.00	05300	ANESTHESIOLOGY	830	45,518	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,875	652,303	2,542,911	0	54.00
60.00	06000	LABORATORY	8,547	279,551	1,435,098	0	60.00
65.00	06500	RESPIRATORY THERAPY	7,122	88,271	932,567	0	65.00
66.00	06600	PHYSICAL THERAPY	15,051	123,561	2,486,181	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,703	44,780	231,690	0	69.00
69.01	06901	CATH LAB	600	70,171	445,915	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	297	179	57	0	76.00
76.01	03480	CANCER CENTER	8,000	214,102	1,675,608	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,830	10,225	7,586	0	90.00
91.00	09100	EMERGENCY	13,214	172,808	3,321,692	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	14,286	1,141,981	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	307,298	2,838,444	39,279,675	-20,204,630	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	8,515	0	192.03
192.04	19204	SMART STEPS	0	0	0	0	192.04
192.05	19205	RESPIRE CARE	0	0	5,481	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)	1,341,610	2,838,446	10,882,584	20,204,630	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.352372	1.000001	0.276955	0.232765	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			8,165	409,846	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000208	0.004722	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 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
5/26/2022 5:03 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	205,570				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,258	457,900			8.00
9.00	00900	HOUSEKEEPING	4,954	0	198,358		9.00
10.00	01000	DIETARY	11,151	0	11,151	61,306	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	666	0	666	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	55,036	117,964	55,036	58,324	30.00
31.00	03100	INTENSIVE CARE UNIT	4,162	23,783	4,162	2,982	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,863	33,296	20,863	0	50.00
50.01	05001	GI LAB	6,730	23,783	6,730	0	50.01
50.02	05002	AMBULATORY CARE UNIT	8,746	23,783	8,746	0	50.02
51.00	05100	RECOVERY ROOM	1,609	14,270	1,609	0	51.00
53.00	05300	ANESTHESIOLOGY	830	0	830	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,875	84,349	16,875	0	54.00
60.00	06000	LABORATORY	8,547	0	8,547	0	60.00
65.00	06500	RESPIRATORY THERAPY	7,122	4,757	7,122	0	65.00
66.00	06600	PHYSICAL THERAPY	15,051	28,539	15,051	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,703	0	1,703	0	69.00
69.01	06901	CATH LAB	600	23,783	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	297	0	297	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	79,593	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)	204,620	457,900	197,408	61,306	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)	4,352,221	467,010	2,523,851	1,898,635	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.171479	1.019895	12.723717	30.969807	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	196,290	13,590	35,558	75,836	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.954857	0.029679	0.179262	1.237008	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 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
5/26/2022 5:03 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
		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	387,679				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,087,960			14.00
15.00	01500	PHARMACY	0	36,233	11,140,849		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	32	0	539,726,266	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	262,918	411,725	4,777	37,271,368	30.00
31.00	03100	INTENSIVE CARE UNIT	33,624	126,387	3,320	4,484,794	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	113,184	41,658	77,250,410	50.00
50.01	05001	GI LAB	0	273,149	594	20,174,880	50.01
50.02	05002	AMBULATORY CARE UNIT	0	110,013	865,931	5,036,326	50.02
51.00	05100	RECOVERY ROOM	0	3,121	607	2,924,848	51.00
53.00	05300	ANESTHESIOLOGY	0	88,989	11,113	8,791,274	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	166,373	7,468	108,019,205	54.00
60.00	06000	LABORATORY	0	106,893	1,472	62,756,882	60.00
65.00	06500	RESPIRATORY THERAPY	0	97,962	6,365	14,867,226	65.00
66.00	06600	PHYSICAL THERAPY	0	30,218	74	19,180,867	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,400	0	10,106,777	69.00
69.01	06901	CATH LAB	0	1,450	163	11,840,395	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	25,232	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	3,897,370	66,797,191	73.00
74.00	07400	RENAL DIALYSIS	0	33	0	690,168	74.00
76.00	03950	DIABETIC EDUCATION	0	2,004	0	0	76.00
76.01	03480	CANCER CENTER	0	70,556	6,137,900	30,903,242	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	91,050	15,110	6,338,098	90.00
91.00	09100	EMERGENCY	91,137	327,856	6,573	46,280,310	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	28,332	140,354	5,986,773	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	387,679	2,087,960	11,140,849	539,726,266	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)	1,371,639	729,059	3,658,784	2,725,041	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.538079	0.349173	0.328412	0.005049	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	23,024	7,780	359,355	16,310	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.059389	0.003726	0.032256	0.000030	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:
5/26/2022 5:03 pm

MCRIF32 - 17.4.174.1

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/26/2022 5:03 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	25,447,250		25,447,250			30.00		
31.00	03100	INTENSIVE CARE UNIT	4,484,794		4,484,794			31.00		
43.00	04300	NURSERY	0		0			43.00		
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	19,910,154	57,340,256	77,250,410	0.150388	0.000000	50.00		
50.01	05001	GI LAB	3,116,098	17,058,782	20,174,880	0.150849	0.000000	50.01		
50.02	05002	AMBULATORY CARE UNIT	17,671	5,018,655	5,036,326	0.870492	0.000000	50.02		
51.00	05100	RECOVERY ROOM	785,159	2,139,689	2,924,848	0.303398	0.000000	51.00		
53.00	05300	ANESTHESIOLOGY	2,070,706	6,720,568	8,791,274	0.037676	0.000000	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,977,874	92,041,331	108,019,205	0.077531	0.000000	54.00		
60.00	06000	LABORATORY	13,105,293	49,651,589	62,756,882	0.138267	0.000000	60.00		
65.00	06500	RESPIRATORY THERAPY	9,991,192	4,876,034	14,867,226	0.152957	0.000000	65.00		
66.00	06600	PHYSICAL THERAPY	2,895,526	16,285,341	19,180,867	0.263324	0.000000	66.00		
69.00	06900	ELECTROCARDIOLOGY	2,579,973	7,526,804	10,106,777	0.067070	0.000000	69.00		
69.01	06901	CATH LAB	4,071,318	7,769,077	11,840,395	0.140360	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	22,944	2,288	25,232	0.005033	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	32,126,028	34,671,163	66,797,191	0.098181	0.000000	73.00		
74.00	07400	RENAL DIALYSIS	593,616	96,552	690,168	0.295501	0.000000	74.00		
76.00	03950	DIABETIC EDUCATION	0	0	0	0.000000	0.000000	76.00		
76.01	03480	CANCER CENTER	8,739	30,894,503	30,903,242	0.435842	0.000000	76.01		
	OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	9,233	6,328,865	6,338,098	0.267387	0.000000	90.00		
91.00	09100	EMERGENCY	7,215,815	39,064,495	46,280,310	0.184376	0.000000	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,442,080	9,382,038	11,824,118	0.816367	0.000000	92.00		
	SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00		
116.00	11600	HOSPICE	0	5,986,773	5,986,773			116.00		
200.00		Subtotal (see instructions)	146,871,463	392,854,803	539,726,266			200.00		
201.00		Less Observation Beds						201.00		
202.00		Total (see instructions)	146,871,463	392,854,803	539,726,266			202.00		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/26/2022 5:03 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	0.150388		50.00
50.01	05001	GI LAB	0.150849		50.01
50.02	05002	AMBULATORY CARE UNIT	0.870492		50.02
51.00	05100	RECOVERY ROOM	0.303398		51.00
53.00	05300	ANESTHESIOLOGY	0.037676		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077531		54.00
60.00	06000	LABORATORY	0.138267		60.00
65.00	06500	RESPIRATORY THERAPY	0.152957		65.00
66.00	06600	PHYSICAL THERAPY	0.263324		66.00
69.00	06900	ELECTROCARDIOLOGY	0.067070		69.00
69.01	06901	CATH LAB	0.140360		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.005033		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.098181		73.00
74.00	07400	RENAL DIALYSIS	0.295501		74.00
76.00	03950	DIABETIC EDUCATION	0.000000		76.00
76.01	03480	CANCER CENTER	0.435842		76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.267387		90.00
91.00	09100	EMERGENCY	0.184376		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.816367		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/26/2022 5:03 pm

			Title XIX	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs	
					Total Costs	Total Costs
					RCE Disallowance	
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,187,935		23,187,935	0
31.00	03100	INTENSIVE CARE UNIT	3,100,552		3,100,552	0
43.00	04300	NURSERY	0		0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,617,530		11,617,530	0
50.01	05001	GI LAB	3,043,360		3,043,360	0
50.02	05002	AMBULATORY CARE UNIT	4,384,083		4,384,083	0
51.00	05100	RECOVERY ROOM	887,394		887,394	0
53.00	05300	ANESTHESIOLOGY	331,223		331,223	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,374,821		8,374,821	0
60.00	06000	LABORATORY	8,677,184		8,677,184	0
65.00	06500	RESPIRATORY THERAPY	2,274,045	0	2,274,045	0
66.00	06600	PHYSICAL THERAPY	5,050,777	0	5,050,777	0
69.00	06900	ELECTROCARDIOLOGY	677,858		677,858	0
69.01	06901	CATH LAB	1,661,912		1,661,912	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	127		127	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	6,558,224		6,558,224	0
74.00	07400	RENAL DIALYSIS	203,945		203,945	0
76.00	03950	DIABETIC EDUCATION	105,813		105,813	0
76.01	03480	CANCER CENTER	13,468,925		13,468,925	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,694,723		1,694,723	0
91.00	09100	EMERGENCY	8,532,965		8,532,965	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	9,652,823		9,652,823	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
116.00	11600	HOSPICE	3,111,197		3,111,197	0
200.00		Subtotal (see instructions)	116,597,416	0	116,597,416	0
201.00		Less Observation Beds	9,652,823		9,652,823	0
202.00		Total (see instructions)	106,944,593	0	106,944,593	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/26/2022 5:03 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	25,447,250		25,447,250			30.00		
31.00	03100	INTENSIVE CARE UNIT	4,484,794		4,484,794			31.00		
43.00	04300	NURSERY	0		0			43.00		
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	19,910,154	57,340,256	77,250,410	0.150388	0.000000	50.00		
50.01	05001	GI LAB	3,116,098	17,058,782	20,174,880	0.150849	0.000000	50.01		
50.02	05002	AMBULATORY CARE UNIT	17,671	5,018,655	5,036,326	0.870492	0.000000	50.02		
51.00	05100	RECOVERY ROOM	785,159	2,139,689	2,924,848	0.303398	0.000000	51.00		
53.00	05300	ANESTHESIOLOGY	2,070,706	6,720,568	8,791,274	0.037676	0.000000	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,977,874	92,041,331	108,019,205	0.077531	0.000000	54.00		
60.00	06000	LABORATORY	13,105,293	49,651,589	62,756,882	0.138267	0.000000	60.00		
65.00	06500	RESPIRATORY THERAPY	9,991,192	4,876,034	14,867,226	0.152957	0.000000	65.00		
66.00	06600	PHYSICAL THERAPY	2,895,526	16,285,341	19,180,867	0.263324	0.000000	66.00		
69.00	06900	ELECTROCARDIOLOGY	2,579,973	7,526,804	10,106,777	0.067070	0.000000	69.00		
69.01	06901	CATH LAB	4,071,318	7,769,077	11,840,395	0.140360	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	22,944	2,288	25,232	0.005033	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	32,126,028	34,671,163	66,797,191	0.098181	0.000000	73.00		
74.00	07400	RENAL DIALYSIS	593,616	96,552	690,168	0.295501	0.000000	74.00		
76.00	03950	DIABETIC EDUCATION	0	0	0	0.000000	0.000000	76.00		
76.01	03480	CANCER CENTER	8,739	30,894,503	30,903,242	0.435842	0.000000	76.01		
	OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	9,233	6,328,865	6,338,098	0.267387	0.000000	90.00		
91.00	09100	EMERGENCY	7,215,815	39,064,495	46,280,310	0.184376	0.000000	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,442,080	9,382,038	11,824,118	0.816367	0.000000	92.00		
	SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00		
116.00	11600	HOSPICE	0	5,986,773	5,986,773			116.00		
200.00		Subtotal (see instructions)	146,871,463	392,854,803	539,726,266			200.00		
201.00		Less Observation Beds						201.00		
202.00		Total (see instructions)	146,871,463	392,854,803	539,726,266			202.00		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
5/26/2022 5:03 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 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
5/26/2022 5:03 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	670,401	0	670,401	17,709	37.86	30.00
31.00	INTENSIVE CARE UNIT	103,156		103,156	1,332	77.44	31.00
43.00	NURSERY	0		0	538	0.00	43.00
200.00	Total (lines 30 through 199)	773,557		773,557	19,579		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	3,729	141,180				
31.00	INTENSIVE CARE UNIT	509	39,417				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	4,238	180,597				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN:14-0160	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Prepared: 5/26/2022 5:03 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	418,463	77,250,410	0.005417	7,447,787	40,345	50.00
50.01	05001	GI LAB	138,936	20,174,880	0.006887	1,373,912	9,462	50.01
50.02	05002	AMBULATORY CARE UNIT	109,514	5,036,326	0.021745	4,069	88	50.02
51.00	05100	RECOVERY ROOM	23,310	2,924,848	0.007970	253,107	2,017	51.00
53.00	05300	ANESTHESIOLOGY	51,884	8,791,274	0.005902	691,148	4,079	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	784,319	108,019,205	0.007261	6,076,351	44,120	54.00
60.00	06000	LABORATORY	362,586	62,756,882	0.005778	4,716,346	27,251	60.00
65.00	06500	RESPIRATORY THERAPY	137,583	14,867,226	0.009254	3,754,427	34,743	65.00
66.00	06600	PHYSICAL THERAPY	228,864	19,180,867	0.011932	1,289,952	15,392	66.00
69.00	06900	ELECTROCARDIOLOGY	56,964	10,106,777	0.005636	1,313,938	7,405	69.00
69.01	06901	CATH LAB	81,217	11,840,395	0.006859	1,913,454	13,124	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1	25,232	0.000040	10,669	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	146,644	66,797,191	0.002195	10,923,306	23,977	73.00
74.00	07400	RENAL DIALYSIS	2,380	690,168	0.003448	272,828	941	74.00
76.00	03950	DIABETIC EDUCATION	2,180	0	0.000000	0	0	76.00
76.01	03480	CANCER CENTER	501,349	30,903,242	0.016223	502	8	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	32,641	6,338,098	0.005150	7,913	41	90.00
91.00	09100	EMERGENCY	289,446	46,280,310	0.006254	2,839,630	17,759	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	279,082	11,824,118	0.023603	997,379	23,541	92.00
200.00		Total (lines 50 through 199)	3,647,363	503,807,449		43,886,718	264,293	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN:14-0160		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 5/26/2022 5:03 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00	
43.00	04300	NURSERY		0	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	17,709	0.00	3,729		30.00	
31.00	03100	INTENSIVE CARE UNIT			0	1,332	0.00	509		31.00	
43.00	04300	NURSERY			0	538	0.00	0		43.00	
200.00		Total (lines 30 through 199)			0	19,579		4,238		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 01/01/2021
To 12/31/2021

Worksheet D
Part IV
Date/Time Prepared:
5/26/2022 5:03 pm

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021

Worksheet D
Part IV
Date/Time Prepared:
5/26/2022 5:03 pm

					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	77,250,410	0.000000	50.00	
50.01	05001	GI LAB	0	0	0	20,174,880	0.000000	50.01	
50.02	05002	AMBULATORY CARE UNIT	0	0	0	5,036,326	0.000000	50.02	
51.00	05100	RECOVERY ROOM	0	0	0	2,924,848	0.000000	51.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	8,791,274	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	108,019,205	0.000000	54.00	
60.00	06000	LABORATORY	0	0	0	62,756,882	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,867,226	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	19,180,867	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10,106,777	0.000000	69.00	
69.01	06901	CATH LAB	0	0	0	11,840,395	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	25,232	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	66,797,191	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	690,168	0.000000	74.00	
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0.000000	76.00	
76.01	03480	CANCER CENTER	0	0	0	30,903,242	0.000000	76.01	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	6,338,098	0.000000	90.00	
91.00	09100	EMERGENCY	0	0	0	46,280,310	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	11,824,118	0.000000	92.00	
200.00		Total (lines 50 through 199)	0	0	0	503,807,449		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN:14-0160	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/26/2022 5:03 pm
--	----------------------	---	--

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)	Hospital Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PPS
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	7,447,787	0	13,812,044	0	50.00
50.01	05001 GI LAB	0.000000	1,373,912	0	4,338,503	0	50.01
50.02	05002 AMBULATORY CARE UNIT	0.000000	4,069	0	2,646,721	0	50.02
51.00	05100 RECOVERY ROOM	0.000000	253,107	0	429,472	0	51.00
53.00	05300 ANESTHESIOLOGY	0.000000	691,148	0	1,608,764	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	6,076,351	0	21,210,957	0	54.00
60.00	06000 LABORATORY	0.000000	4,716,346	0	4,928,248	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	3,754,427	0	1,231,083	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,289,952	0	1,129,501	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	1,313,938	0	2,885,497	0	69.00
69.01	06901 CATH LAB	0.000000	1,913,454	0	2,395,444	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	10,669	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	10,923,306	0	9,522,931	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	272,828	0	34,272	0	74.00
76.00	03950 DIABETIC EDUCATION	0.000000	0	0	0	0	76.00
76.01	03480 CANCER CENTER	0.000000	502	0	12,352,090	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	7,913	0	3,027,920	0	90.00
91.00	09100 EMERGENCY	0.000000	2,839,630	0	6,668,901	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	997,379	0	2,669,500	0	92.00
200.00	Total (lines 50 through 199)		43,886,718	0	90,891,848	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN:14-0160		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part V Date/Time Prepared: 5/26/2022 5:03 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	0.150388	13,812,044	0	0	2,077,166	50.00
50.01	05001	GI LAB	0.150849	4,338,503	0	0	654,459	50.01
50.02	05002	AMBULATORY CARE UNIT	0.870492	2,646,721	0	0	2,303,949	50.02
51.00	05100	RECOVERY ROOM	0.303398	429,472	0	0	130,301	51.00
53.00	05300	ANESTHESIOLOGY	0.037676	1,608,764	0	0	60,612	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077531	21,210,957	0	0	1,644,507	54.00
60.00	06000	LABORATORY	0.138267	4,928,248	315	0	681,414	60.00
65.00	06500	RESPIRATORY THERAPY	0.152957	1,231,083	0	0	188,303	65.00
66.00	06600	PHYSICAL THERAPY	0.263324	1,129,501	0	0	297,425	66.00
69.00	06900	ELECTROCARDIOLOGY	0.067070	2,885,497	0	0	193,530	69.00
69.01	06901	CATH LAB	0.140360	2,395,444	0	0	336,225	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.005033	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	0.098181	9,522,931	624	68,245	934,971	73.00
74.00	07400	RENAL DIALYSIS	0.295501	34,272	0	0	10,127	74.00
76.00	03950	DIABETIC EDUCATION	0.000000	0	0	0	0	76.00
76.01	03480	CANCER CENTER	0.435842	12,352,090	0	0	5,383,560	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.267387	3,027,920	0	0	809,626	90.00
91.00	09100	EMERGENCY	0.184376	6,668,901	0	0	1,229,585	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.816367	2,669,500	0	0	2,179,292	92.00
200.00		Subtotal (see instructions)		90,891,848	939	68,245	19,115,052	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
202.00		Only Charges						
202.00		Net Charges (line 200 - line 201)		90,891,848	939	68,245	19,115,052	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
5/26/2022 5:03 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	0	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	0	54.00
60.00	06000	LABORATORY	44	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	61	6,700	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	0	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	105	6,700	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	105	6,700	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN:14-0160	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/26/2022 5:03 pm
		Title XVIII	Hospital	PPS
Cost Center Description				
				1.00
	PART I - ALL PROVIDER COMPONENTS			
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		17,709	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		17,709	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)		10,337	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)		3,729	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)		23,187,935	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)		23,187,935	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)		23,187,935	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)		1,309.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,882,715	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)		4,882,715	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN:14-0160	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/26/2022 5:03 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	3,100,552	1,332	2,327.74	509	1,184,820	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)					6,320,803	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					12,388,338	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)					180,597	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					264,293	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					444,890	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					11,943,448	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)					7,372	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,309.39	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					9,652,823	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021

Worksheet D-1

Date/Time Prepared:
5/26/2022 5:03 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	670,401	23,187,935	0.028912	9,652,823	279,082
91.00	Nursing Program cost	0	23,187,935	0.000000	9,652,823	0
92.00	Allied health cost	0	23,187,935	0.000000	9,652,823	0
93.00	All other Medical Education	0	23,187,935	0.000000	9,652,823	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN:14-0160	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/26/2022 5:03 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		6,578,283	30.00
31.00	03100	INTENSIVE CARE UNIT		1,748,933	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.150388	7,447,787	50.00
50.01	05001	GI LAB	0.150849	1,373,912	50.01
50.02	05002	AMBULATORY CARE UNIT	0.070492	4,069	50.02
51.00	05100	RECOVERY ROOM	0.303398	253,107	51.00
53.00	05300	ANESTHESIOLOGY	0.037676	691,148	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077531	6,076,351	54.00
60.00	06000	LABORATORY	0.138267	4,716,346	60.00
65.00	06500	RESPIRATORY THERAPY	0.152957	3,754,427	65.00
66.00	06600	PHYSICAL THERAPY	0.263324	1,289,952	66.00
69.00	06900	ELECTROCARDIOLOGY	0.067070	1,313,938	69.00
69.01	06901	CATH LAB	0.140360	1,913,454	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.005033	10,669	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.098181	10,923,306	73.00
74.00	07400	RENAL DIALYSIS	0.295501	272,828	74.00
76.00	03950	DIABETIC EDUCATION	0.000000	0	76.00
76.01	03480	CANCER CENTER	0.435842	502	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.267387	7,913	90.00
91.00	09100	EMERGENCY	0.184376	2,839,630	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.816367	997,379	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		43,886,718	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		43,886,718	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0160	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/26/2022 5:03 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)	6,057,704		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	172,173		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)	234,548		2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	71,001		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)	79.80		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)	3.54		30.00
31.00	Percentage of Medicaid patient days (see instructions)	18.58		31.00
32.00	Sum of lines 30 and 31	22.12		32.00
33.00	Allowable disproportionate share percentage (see instructions)	7.45		33.00
34.00	Disproportionate share adjustment (see instructions)	153,282		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0160	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/26/2022 5:03 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)	0.000084636	0.000108408	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	701,632	779,675	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	524,782	196,521	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	721,303		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	46.00
47.00	Subtotal (see instructions)	9,410,011		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only) (see instructions)	403,050		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		9,410,011	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		625,201	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		366,476	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		10,401,688	59.00
60.00	Primary payer payments		3,516	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		10,398,172	61.00
62.00	Deductibles billed to program beneficiaries		1,053,528	62.00
63.00	Coinsurance billed to program beneficiaries		4,823	63.00
64.00	Allowable bad debts (see instructions)		272,697	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		177,253	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		236,854	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		9,517,074	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		38,884	70.93
70.94	HRR adjustment amount (see instructions)		-167,800	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0160	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/26/2022 5:03 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)	2021	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)	2022	151,686	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)		9,539,844	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		9,642,416	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-102,572	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		370,550	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	1.0061961513	1.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.9821	0.9761	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	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 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/26/2022 5:03 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	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,057,704	0	6,057,704		6,057,704	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,172,173	0		2,172,173	2,172,173	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	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	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	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	234,548	0	234,548		234,548	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	71,001	0		71,001	71,001	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	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	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	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	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	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	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0745	0.0745	0.0745	0.0745		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	153,282	0	112,825	40,457	153,282	11.00
11.01	Uncompensated care payments	36.00	721,303	0	524,782	196,521	721,303	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	0	12.00
13.00	Subtotal (see instructions)	47.00	9,410,011	0	6,929,859	2,480,152	9,410,011	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,410,011	0	6,929,859	2,480,152	9,410,011	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	625,201	0	465,356	159,845	625,201	16.00
17.00	Special add-on payments for new technologies	54.00	366,476	0	217,821	148,655	366,476	17.00
17.01	Net organ acquisition cost							17.01

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/26/2022 5:03 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
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	7,613,036	2,788,652	10,401,688
		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	620,979	0	461,603	159,376	620,979
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	4,222	0	3,753	469	4,222
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	625,201	0	465,356	159,845	625,201
		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				0.000000	0.054394	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				151,686	151,686
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/26/2022 5:03 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	6,057,704	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,172,173		8,229,877	8,229,877	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	234,548	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	71,001		305,549	305,549	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	0.0745	0.0745	0.0745		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	153,282	0	153,282	153,282	11.00
11.01	Uncompensated care payments	36.00	721,303	524,782	196,521	721,303	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00		0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,410,011	524,782	8,885,229	9,410,011	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,410,011	524,782	8,885,229	9,410,011	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	625,201	0	625,201	625,201	16.00
17.00	Special add-on payments for new technologies	54.00	366,476	0	366,476	366,476	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			524,782	9,876,906	10,401,688	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/26/2022 5:03 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	620,979	0	620,979	620,979	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	4,222	0	4,222	4,222	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	625,201	0	625,201	625,201	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	151,686		151,686	151,686	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	38,884	0	38,884	38,884	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-167,800	0	-167,800	-167,800	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	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 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/26/2022 5:03 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		6,805	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		19,115,052	2.00
3.00	OPPS payments		13,412,600	3.00
4.00	Outlier payment (see instructions)		152,033	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		15,712,573	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		86.33	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)		6,805	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		69,184	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)		69,184	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)		69,184	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		62,379	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)		6,805	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)		13,564,633	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)		2,220,500	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		11,350,938	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		11,350,938	30.00
31.00	Primary payer payments		144	31.00
32.00	Subtotal (line 30 minus line 31)		11,350,794	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)		546,870	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		355,466	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		445,460	36.00
37.00	Subtotal (see instructions)		11,706,260	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		11,706,260	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		11,786,702	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)		-80,442	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		270,448	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 01/01/2021
To 12/31/2021Worksheet E-1
Part I
Date/Time Prepared:
5/26/2022 5:03 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		9,842,681		11,884,731	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	10/07/2021	200,265	10/07/2021	98,029	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)		-200,265		-98,029	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)		9,642,416		11,786,702	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		102,572		80,442	6.02	
7.00	Total Medicare program liability (see instructions)		9,539,844		11,706,260	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 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Prepared: 5/26/2022 5:03 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 (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)			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:

Worksheet G

From 01/01/2021
To 12/31/2021Date/Time Prepared:
5/26/2022 5:03 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	56,077,650	0	0	0	1.00
2.00	Temporary investments	8,896,356	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	24,902,925	0	0	0	4.00
5.00	Other receivable	26,569,262	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	5,922,269	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)	122,368,462	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	20,557,857	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	20,557,857	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	6,796,201	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	2,595,396	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,391,597	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	152,317,916	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	334,987	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,824,745	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	25,645,213	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	31,804,945	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	5,165,154	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5,165,154	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	36,970,099	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	115,347,817	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)	115,347,817	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	152,317,916	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021

Worksheet G-1

Date/Time Prepared:
5/26/2022 5:03 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		84,367,101		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		30,862,856				2.00
3.00	Total (sum of line 1 and line 2)		115,229,957		0		3.00
4.00	PRIOR PERIOD ADJ	117,860		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)		117,860		0		10.00
11.00	Subtotal (line 3 plus line 10)		115,347,817		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)		115,347,817		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 01/01/2021
To 12/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
5/26/2022 5:03 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	45,709,252		45,709,252	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)	45,709,252		45,709,252	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	4,737,634		4,737,634	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	4,737,634		4,737,634	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	50,446,886		50,446,886	17.00
18.00	Ancillary services	111,060,956	356,341,639	467,402,595	18.00
19.00	Outpatient services	9,452,269	61,197,009	70,649,278	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	0	5,986,773	5,986,773	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)	170,960,111	423,525,421	594,485,532	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		129,105,768		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)		129,105,768		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN:14-0160

Period:
From 01/01/2021
To 12/31/2021

Worksheet G-3

Date/Time Prepared:
5/26/2022 5:03 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	594,485,532	1.00
2.00	Less contractual allowances and discounts on patients' accounts	448,209,611	2.00
3.00	Net patient revenues (line 1 minus line 2)	146,275,921	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	129,105,768	4.00
5.00	Net income from service to patients (line 3 minus line 4)	17,170,153	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	4,087,843	6.00
7.00	Income from investments	667,636	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	8,562,436	24.00
24.01	MEDICAID ASSESSMENT REV	83,304	24.01
24.02	SALE OF ASSETS	42,968	24.02
24.03	OTHER	37,595	24.03
24.04	NET ASSETS RELEASED	210,921	24.04
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	13,692,703	25.00
26.00	Total (line 5 plus line 25)	30,862,856	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	30,862,856	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN:14-0160

Period:

Worksheet 0

Hospice CCN: 14-1560

From 01/01/2021
To 12/31/2021

Date/Time Prepared:

5/26/2022 5:03 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	10,733	10,733	0	10,733	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	115,407	115,407	0	115,407	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	84	84	0	84	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	49,400	49,400	0	49,400	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	140,354	140,354	0	140,354	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	192,670	0	192,670	0	192,670	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**	25,875	0	25,875	0	25,875	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	640,893	577,636	1,218,529	0	1,218,529	28.00
29.00	LPN/LVN**	90,880	0	90,880	0	90,880	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**	171,506	0	171,506	0	171,506	33.00
34.00	SPIRITUAL COUNSELING**	19,746	0	19,746	0	19,746	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	28,180	28,180	0	28,180	38.00
39.00	PATIENT TRANSPORTATION**	0	14,798	14,798	0	14,798	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	412	0	412	0	412	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	1,141,982	936,592	2,078,574	0	2,078,574	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 01/01/2021

To 12/31/2021

Date/Time Prepared:
5/26/2022 5:03 pm

		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	10,733	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	115,407	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	84	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	49,400	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	140,354	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	192,670	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	25,875	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	1,218,529	28.00
29.00	LPN/LVN**	0	90,880	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	171,506	33.00
34.00	SPIRITUAL COUNSELING**	0	19,746	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	28,180	38.00
39.00	PATIENT TRANSPORTATION**	0	14,798	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	412	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	2,078,574	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 01/01/2021 To 12/31/2021	Worksheet 0-2
Hospice CCN: 14-1560	Date/Time Prepared: 5/26/2022 5:03 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						25.00
26.00	PHYSICIAN SERVICES	25,359	0	25,359	0	25,359	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	628,119	566,123	1,194,242	0	1,194,242	28.00
29.00	LPN/LVN	89,068	0	89,068	0	89,068	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	168,088	0	168,088	0	168,088	33.00
34.00	SPIRITUAL COUNSELING	19,352	0	19,352	0	19,352	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	27,619	27,619	0	27,619	38.00
39.00	PATIENT TRANSPORTATION	0	14,503	14,503	0	14,503	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	404	0	404	0	404	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 *	930,390	608,245	1,538,635	0	1,538,635	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	25,359	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	1,194,242	28.00
29.00	LPN/LVN	0	89,068	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	168,088	33.00
34.00	SPIRITUAL COUNSELING	0	19,352	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	27,619	38.00
39.00	PATIENT TRANSPORTATION	0	14,503	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	404	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	1,538,635	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 01/01/2021 To 12/31/2021	Worksheet 0-3
		Hospice CCN: 14-1560		Date/Time Prepared: 5/26/2022 5:03 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	510	0	510	0	510	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	12,628	11,381	24,009	0	24,009	28.00
29.00	LPN/LVN	1,791	0	1,791	0	1,791	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	3,379	0	3,379	0	3,379	33.00
34.00	SPIRITUAL COUNSELING	389	0	389	0	389	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	555	555	0	555	38.00
39.00	PATIENT TRANSPORTATION	0	292	292	0	292	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	8	0	8	0	8	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 *	18,705	12,228	30,933	0	30,933	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	510	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	24,009	28.00
29.00	LPN/LVN	0	1,791	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	3,379	33.00
34.00	SPIRITUAL COUNSELING	0	389	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	555	38.00
39.00	PATIENT TRANSPORTATION	0	292	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	8	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	30,933	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 01/01/2021 To 12/31/2021	Worksheet 0-4
		Hospice CCN: 14-1560		Date/Time Prepared: 5/26/2022 5:03 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	6	0	6	0	6	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	146	132	278	0	278	28.00
29.00	LPN/LVN	21	0	21	0	21	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	39	0	39	0	39	33.00
34.00	SPIRITUAL COUNSELING	5	0	5	0	5	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	6	6	0	6	38.00
39.00	PATIENT TRANSPORTATION	0	3	3	0	3	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 *	217	141	358	0	358	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	6	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	278	28.00
29.00	LPN/LVN	0	21	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	39	33.00
34.00	SPIRITUAL COUNSELING	0	5	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	6	38.00
39.00	PATIENT TRANSPORTATION	0	3	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	358	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 01/01/2021

Date/Time Prepared:

To 12/31/2021

5/26/2022 5:03 pm

Descriptions		Hospice I		TOTAL EXPENSES	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	(sum of cols. 1 + 2)	
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	14,286	14,286	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	10,733	316,277	327,010	3.00
4.00	ADMINISTRATIVE & GENERAL	115,407	615,846	731,253	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	84	9,893	9,977	10.00
11.00	MEDICAL RECORDS	0	30,227	30,227	11.00
12.00	STAFF TRANSPORTATION	49,400	0	49,400	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	13.00
14.00	PHARMACY	140,354	46,094	186,448	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	192,670	0	192,670	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	1,538,635	0	1,538,635	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	30,933	0	30,933	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	358	0	358	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	0	0	0	99.00
100.00	TOTAL	2,078,574	1,032,623	3,111,197	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN:14-0160

Period:

Worksheet 0-6

Hospice CCN: 14-1560

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:
5/26/2022 5:03 pm

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	14,286		14,286				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	327,010	0	0	327,010			3.00
4.00	ADMINISTRATIVE & GENERAL	731,253	0	14,238	0		745,491	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	9,977	0	0	0		9,977	10.00
11.00	MEDICAL RECORDS	30,227	0	0	0		30,227	11.00
12.00	STAFF TRANSPORTATION	49,400	0	0	0		49,400	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0		0	13.00
14.00	PHARMACY	186,448	0	0	0		186,448	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0		0	15.00
16.00	OTHER GENERAL SERVICE	192,670	0	0	0		192,670	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	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,538,635			320,492	1,859,127		51.00
52.00	HOSPICE INPATIENT RESPITE CARE	30,933	0	27	6,443	37,403		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	358	0	21	75	454		53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	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	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	0	99.00
100.00	TOTAL	3,111,197	0	14,286	327,010	3,111,197		100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN:14-0160

Period:

Worksheet 0-6

Hospice CCN: 14-1560

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:
5/26/2022 5:03 pm

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	745,491						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	3,144	0			0		10.00
11.00	MEDICAL RECORDS	9,525	0			0		11.00
12.00	STAFF TRANSPORTATION	15,567	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0			0		13.00
14.00	PHARMACY	58,754	0			0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0			0		15.00
16.00	OTHER GENERAL SERVICE	60,715	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	585,856						51.00
52.00	HOSPICE INPATIENT RESPITE CARE	11,787	0		0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	143	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	745,491	0		0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN:14-0160

Period:

Worksheet 0-6

Hospice CCN: 14-1560

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:
5/26/2022 5:03 pm

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	13,121				10.00
11.00	MEDICAL RECORDS	0		39,752			11.00
12.00	STAFF TRANSPORTATION	0			64,967		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						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	12,859	38,960	64,147	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	259	783	685	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	3	9	135	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	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	13,121	39,752	64,967	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN:14-0160

Period:

Worksheet 0-6

Hospice CCN: 14-1560

From 01/01/2021
To 12/31/2021Part I
Date/Time Prepared:
5/26/2022 5:03 pm

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	245,202					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		253,385			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	242,106	0	250,186		3,053,241	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2,585	0	2,671	0	56,173	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	511	0	528	0	1,783	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	245,202	0	253,385	0	3,111,197	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 01/01/2021
To 12/31/2021Part II
Date/Time Prepared:
5/26/2022 5:03 pm

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	855					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		14,334				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	13,145			3.00
4.00	ADMINISTRATIVE & GENERAL	855	14,286	0	-745,491	2,365,706	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	9,977	10.00
11.00	MEDICAL RECORDS	0	0	0	0	30,227	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	49,400	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	186,448	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	192,670	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			12,883	0	1,859,127	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	27	259	0	37,403	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	21	3	0	454	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	0	0	0	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	14,286	327,010		745,491	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.996651	24.877140		0.315124	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 01/01/2021
To 12/31/2021Part II
Date/Time Prepared:
5/26/2022 5:03 pm

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:
From 01/01/2021

Worksheet 0-6

Hospice CCN: 14-1560

To 12/31/2021

Part II

Date/Time Prepared:
5/26/2022 5:03 pm

Cost Center Descriptions		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	13,145					10.00
11.00	MEDICAL RECORDS		13,145				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	12,883	12,883	15,643	15,643	15,643	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	259	259	167	167	167	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	3	3	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)	13,121	39,752	64,967	0	245,202	100.00
101.00	UNIT COST MULTIPLIER	0.998174	3.024116	4.100675	0.000000	15.476993	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 01/01/2021
To 12/31/2021Part II
Date/Time Prepared:
5/26/2022 5:03 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	253,385	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	15.993499	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE		Provider CCN:14-0160	Period: From 01/01/2021 To 12/31/2021	Worksheet 0-7
		Hospice CCN: 14-1560	Date/Time Prepared: 5/26/2022 5:03 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	0.263324	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	0.098181	0	155,733	0	4.00	
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00	
6.00	LABORATORY	60.00	0.138267	0	0	0	6.00	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.005033	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	0.000000	0	0	0	10.00	
10.01	CANCER CENTER	76.01	0.435842	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	15,290	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 01/01/2021
To 12/31/2021Date/Time Prepared:
5/26/2022 5:03 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)			3,068,531	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			12,883	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			238.18	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	12,151	72		9.00
10.00	Program cost (line 8 times line 9)	2,894,125	17,149		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)			56,173	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			259	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			216.88	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	220	0		14.00
15.00	Program cost (line 13 times line 14)	47,714	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)			1,783	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			3	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			594.33	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	1	0		19.00
20.00	Program cost (line 18 times line 19)	594	0		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			3,126,487	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			13,145	22.00
23.00	Average cost per diem (line 21 divided by line 22)			237.85	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN:14-0160	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Prepared: 5/26/2022 5:03 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		620,979	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		4,222	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)		32.39	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)		625,201	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