AND SETTLEMENT	IDSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION SUMMARY	Provider Con: 14-13	From 10/01/2018 To 09/30/2019	Parts I-III Date/Time Prepared: 2/26/2020 1:37 pm
PART I - COST	REPORT STATUS			
Provi der	1. [X] Electronically filed cost report		Date: 2/26/202	20 Time: 1:37 pm
use only	2. [] Manually submitted cost report 3. [0] If this is an amended report enter the number 4. [F] Medicare Utilization. Enter "F" for full or "		er resubmitted this co	ost report
Contractor use only	5. [1]Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for (3) Settled with Audit 9. [N] Final Report for (4) Reopened (5) Amended	for this Provider CCN		

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by TAYLORVILLE MEMORIAL HOSPITAL (14-1339) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) CHRISTINE GOLDESBERRY-CURRY

Officer or Administrator of Provider(s)

DIRECTOR OF FINANCE

Title

(Dated when report is electronically signed.)

Date

		Title XVIII				
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1.00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
Hospi tal	0	-343, 323	-1, 147, 752	0	0	1. 00
Subprovi der - IPF	0	0	0		0	2. 00
Subprovi der - I RF	0	0	0		0	3. 00
Swing bed - SNF	0	-70, 002	0		0	5. 00
Swing bed - NF	0			ļ	0	6. 00
Total	0	-413, 325	-1, 147, 752	0	0	200. 00
	PART III - SETTLEMENT SUMMARY Hospital Subprovider - IPF Subprovider - IRF Swing bed - SNF Swing bed - NF	1.00	Cost Center Description	Cost Center Description	Cost Center Description	Cost Center Description

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems TAYLORVILLE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1339 Peri od: Worksheet S-2 From 10/01/2018 To 09/30/2019 Part I Date/Time Prepared: 2/26/2020 1:37 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 201 EAST PLEASANT STREET 1.00 PO Box: 1.00 Ci ty: TAYLORVILLE State: IL Zi p Code: 62568 County: CHRISTIAN 2.00 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 TAYLORVILLE MEMORIAL 141339 99914 09/01/2004 N 0 N 3.00 HOSPI TAI Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovider - (Other) Swing Beds - SNF 6.00 6.00 TAYLORVILLE MEMORIAL-147339 99914 0 N 7.00 09/01/2004 N 7 00 SWR 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital - Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2018 09/30/2019 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3 00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for Ν N 22.00 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. 22.01 Did this hospital receive interim uncompensated care payments for this Ν Ν 22.01 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) Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 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 22.03 Did this hospital receive a geographic reclassification from urban to 22 03 N N N 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. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 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.

	in-State	In-State	Out-or	Out-or	wearcara	other	
	Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
	pai d days	eligible	Medi cai d	Medi cai d		days	
		unpai d	paid days	eligible			
		days		unpai d			
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
24.00 If this provider is an IPPS hospital, enter the	0	0	0	0	0	0	24. 00
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.							

Health Financial Systems TAYLORVILL	E MEMORIA	_ HOSPITAL			In Lie	u of For	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CC	CN: 14-1339	Peri od:		Workshe		
				From 10/0 To 09/3	30/2018	Part I Date/Ti 2/26/20		
	In-State	In-State	Out-of	Out-of	Medi ca	aid 0	ther) piii
	Medicaid paid days	Medicaid eligible	State Medicaid	State Medi cai d	HMO da	·	li cai d lays	
		unpai d	pai d days	el i gi bl e			-5-	
	1 00	days	2.00	unpai d	F 0/		00	
25.00 If this provider is an IRF, enter the in-state	1.00	2.00	3. 00	4.00	5. 00	0	. 00	25. 00
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.				Urban /	Dural S	Date of	Coogr	
				1.		2.0		
26.00 Enter your standard geographic classification (not wag		at the beg	ginning of th	ne	2			26. 00
cost reporting period. Enter "1" for urban or "2" for 27.00 Enter your standard geographic classification (not wag		at the end	of the cos	+	2			27. 00
reporting period. Enter in column 1, "1" for urban or	"2" for r	ural. If ap			_			27.00
enter the effective date of the geographic reclassific 35.00 If this is a sole community hospital (SCH), enter the			'U etatue in		0	ļ		35. 00
effect in the cost reporting period.	number of	perrous so	ii status iii					35.00
				Begi n		Endi		
36.00 Enter applicable beginning and ending dates of SCH sta	itus. Subs	cript line	36 for number	1. er	00	2.0	00	36. 00
of periods in excess of one and enter subsequent dates	S.	·						
37.00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	the numbe	r of period	ds MDH status	5	С			37. 00
37.01 Is this hospital a former MDH that is eligible for the								37. 01
accordance with FY 2016 OPPS final rule? Enter "Y" for	yes or "	N" for no.	(see					
instructions) 38.00 If line 37 is 1, enter the beginning and ending dates	of MDH st	atus. If li	ne 37 is					38. 00
greater than 1, subscript this line for the number of	periods i	n excess of	one and					
enter subsequent dates.				Y	'N	Y/	N	
				1.	00	2. (00	
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i),					1	N		39. 00
1 "Y" for yes or "N" for no. Does the facility meet the				'				
accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter	in column 2	Y" for yes	5				
or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction	adj ustmen	t? Enter "Y	" for yes o	r N	J	N		40. 00
"N" for no in column 1, for discharges prior to Octobe			es or "N" fo	or				
no in column 2, for discharges on or after October 1.	(see inst	ructions)			V	XVIII	XIX	
					1.00	_	3.00	
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment	for disp	roportionat	o chara in	accordance	N	N	N	45. 00
with 42 CFR Section §412.320? (see instructions)		•			l iv	IN IN	IN	45.00
46.00 Is this facility eligible for additional payment excep					N	N	N	46. 00
pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. Pt. III.	L, Pt. I	ii and wkst	. L-1, Pt. 1	through				
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS ca					N	N	N	47. 00
48.00 Is the facility electing full federal capital payment? Teaching Hospitals	P Enter "	Y" for yes	or "N" for I	10.	N	N N	N	48. 00
56.00 Is this a hospital involved in training residents in a	approved G	ME programs	? Enter "Y	for yes	N			56. 00
or "N" for no.								F7 00
57.00 If line 56 is yes, is this the first cost reporting pe GME programs trained at this facility? Enter "Y" for					1 N			57. 00
is "Y" did residents start training in the first month	of this	cost report	ing period?	Enter "Y				
for yes or "N" for no in column 2. If column 2 is "Y" "N", complete Wkst. D, Parts III & IV and D-2, Pt. II,			E-4. IT CO	umn 2 is				
58.00 If line 56 is yes, did this facility elect cost reimbu	ırsement f	or physicia	ans' services	s as	N			58. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, c 59.00 Are costs claimed on line 100 of Worksheet A? If yes,	•		P† I		N			59. 00
57. 00 Pile 60313 Challing on Thie 100 of Worksheet A: 11 yes,	Comprete	WKSt. D Z,	NAHE 413.8	5 Worksh	neet A	Pass-Th	nrough	37.00
			Y/N	Lin	e #	Qual i fi		
						Cri teri d	л соае	
			1. 00	2.	00	3. (00	
60.00 Are you claiming nursing and allied health education (any programs that meet the criteria under §413.85? (s			N					60.00
programs that most the direction dider 3410.00: (3	1113 LT U	0.11 0113)	ı	ı		1	'	1

llool +b	Financial Systems TAVI ODVIII	LE MEMO	DIAL HOCDITAL		la lia	w of Form CMC (DEED 10
	Financial Systems TAYLORVIL AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC	F	eriod: rom 10/01/2018 o 09/30/2019		pared:
		Y/N	IME	Direct GME	IME	Direct GME	7 piii
		1. 00	2. 00	3. 00	4.00	5. 00	
61. 01	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports	N			0.00	0.00	61. 00
61. 02	ending and submitted before March 23, 2010. (see instructions) 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						61. 02
61. 03	ACA). (see instructions) 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
	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
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. 00	2. 00	3.00	4. 00	
	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
	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61. 20
						1.00	
	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital				od for which	0.00	62. 00
62. 01	your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC programmer.	ctions) a Teachi	ng Health Cent	ter (THC) into			62. 01
	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se	er Setti	ngs		peri od? Enter	N	63. 00
	"Y" for yes or "N" for no in column 1. If yes, comple			57. (see instri	uctions)		
				Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				Si te 1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in No	opprovi o	der Settings				

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)

0.000000 64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1339 Peri od: Worksheet S-2 From 10/01/2018 Part I 09/30/2019 Date/Time Prepared: 2/26/2020 1:37 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 0. 00 0. 00 0.000000 65.00 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) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 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 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 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) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 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) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O Ν N 71.00 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) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 Ν subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 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)

HOSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CO	CN: 14-1339	Peri od: From 10/01/2018 To 09/30/2019		epared:	
					1. 00		
80. 00 81. 00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes Is this a LTCH co-located within another hospital for part o "Y" for yes and "N" for no.			ng period? Enter	N N	80. 00 81. 00	
85. 00 86. 00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) Did this facility establish a new Other subprovider (excluder §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00	
87. 00							
	1000(d) (1) (b) (v1): Eliter 1 101 yes of N 101 110.			V 1. 00	XI X 2. 00		
90. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospita	L comuleoc2 Fr	tor "V" for	N	Υ	90.00	
	yes or "N" for no in the applicable column.						
91. 00	Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the appl			N	N	91. 00	
92. 00	Are title XIX NF patients occupying title XVIII SNF beds (duinstructions) Enter "Y" for yes or "N" for no in the applical		on)? (see		N	92. 00	
93. 00	Does this facility operate an ICF/IID facility for purposes		d XIX? Enter	N	N	93. 00	
94. 00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, a	and "N" for no	o in the	N	N	94. 00	
95. 00	applicable column. If line 94 is "Y", enter the reduction percentage in the app	licable column	١.	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					96. 00	
97. 00 98. 00	applicable column. If line 96 is "Y", enter the reduction percentage in the app Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" fo	terns and resi	dents post	0. 00 Y	0. 00 Y	97. 00 98. 00	
98. 01	column 1 for title V, and in column 2 for title XIX.				Y	98. 01	
98. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the call bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of for title V, and in column 2 for title XIX.			Y	Y	98. 02	
98. 03	Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye: for title V, and in column 2 for title XIX.				N	98. 03	
98. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.			d N	N	98. 04	
98. 05	Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c column 2 for title XIX.				Y	98. 05	
98. 06	Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98. 06	
105 00	Rural Providers Does this hospital qualify as a CAH?			Y		105. 00	
	If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	inclusive meth	nod of payme			106. 00	
107. 00	7.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R N training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost					107. 00	
108. 00	reimbursed. If yes complete Wkst. D-2, Pt. II. 08.00 s this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					108. 00	
		Physi cal	Occupati on		Respi ratory		
100.00	If this hospital qualifies as a CAH or a cost provider, are	1.00 N	2.00 N	3. 00 N	4. 00 N	109. 00	

therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		
,	1.00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110. 00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provid	der CCN: 14-1339	Peri od:	Worksheet S	-2
		From 10/01/201 To 09/30/201	8 Part I	repare
		1. 00	2.00	
11.00 If this facility qualifies as a CAH, did it participate in the Fronti Health Integration Project (FCHIP) demonstration for this cost repor "Y" for yes or "N" for no in column 1. If the response to column 1 is integration prong of the FCHIP demo in which this CAH is participatin Enter all that apply: "A" for Ambulance services; "B" for additional for tele-health services.	ting period? Enter s Y, enter the ng in column 2.	N	2.00	111.
		1.	00 2.00 3.0	0
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for is yes, enter the method used (A, B, or E only) in column 2. If colur 3 either "93" percent for short term hospital or "98" percent for lor psychiatric, rehabilitation and long term hospitals providers) based Pub. 15-1, chapter 22, §2208.1.	mn 2 is "E", enter ng term care (incl on the definitior	in column udes in CMS		115.
16.00 s this facility classified as a referral center? Enter "Y" for yes of the state of the		"N" for \\		116. 117.
18.00 s the malpractice insurance a claims-made or occurrence policy? Enter claim-made. Enter 2 if the policy is occurrence.	er 1 if the policy	is 1		118.
profile made. Effer 2 11 the portey 13 occurrence.	Premi ums	Losses	Insurance	
	1. 00	2.00	3.00	
8.01 List amounts of malpractice premiums and paid losses:	24, 7	'35	0	0 118.
		1. 00	2.00	
8.02 Are malpractice premiums and paid losses reported in a cost center of Administrative and General? If yes, submit supporting schedule listing and amounts contained therein. 9.00 DO NOT USE THIS LINE 10.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column	ing cost centers s provision in AC <i>F</i>	N N	N	118. 119. 120.
"N" for no. Is this a rural hospital with < 100 beds that qualifies the Hold Harmless provision in ACA §3121 and applicable amendments? (see Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implantable do	for the Outpatient instructions)	Y		121
patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as defined in a Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", the Worksheet A line number where these taxes are included.				122
Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes and	d "N" for no. If	N		125
yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, enter the cincolumn 1 and termination date, if applicable, in column 2.	certification date	•		126
7.00 If this is a Medicare certified heart transplant center, enter the co in column 1 and termination date, if applicable, in column 2.	ertification date			127
3.00 f this is a Medicare certified liver transplant center, enter the coin column 1 and termination date, if applicable, in column 2.				128
9.00 f this is a Medicare certified lung transplant center, enter the cercolumn 1 and termination date, if applicable, in column 2. 2.00 f this is a Medicare certified pancreas transplant center, enter the		n		129
date in column 1 and termination date, if applicable, in column 2. 1.00 f this is a Medicare certified intestinal transplant center, enter				131
date in column 1 and termination date, if applicable, in column 2. 2.00 f this is a Medicare certified islet transplant center, enter the co				132
in column 1 and termination date, if applicable, in column 2. 3.00 f this is a Medicare certified other transplant center, enter the co	ertification date			133
in column 1 and termination date, if applicable, in column 2. 4.00 If this is an organ procurement organization (OPO), enter the OPO nur and termination date, if applicable, in column 2.	mber in column 1			134
All Providers		Y		
.0.00 Are there any related organization or home office costs as defined i			14H058	140.

column 2, zip code in column 3,								
CBSA in column 4, FTE/Campus in								
column 5 (see instructions)								
						1. 00		
Health Information Technology (HIT) i								
167.00 Is this provider a meaningful user un	der §1886(n)? En	ter "Y" for yes or "N'	" for no			Υ	167. 00	
168.00 If this provider is a CAH (line 105 is	s "Y") and is a m	eaningful user (line 1	167 is "	Y"), enter	the		168. 00	
reasonable cost incurred for the HIT	assets (see instr	uctions)						
168.01 If this provider is a CAH and is not					shi p		168. 01	
exception under §413.70(a)(6)(ii)? En							00169.00	
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)								
					ji nni ng	Endi ng		
					1. 00	2. 00		
170.00 Enter in columns 1 and 2 the EHR begin	nning date and en	ding date for the repo	orting				170. 00	
period respectively (mm/dd/yyyy)								
					4 00	0.00		
474 00 0 11 447 1 111111 1 1 1 1 1 1 1 1 1 1 1 1					1. 00	2. 00	0.171.00	
171.00 If line 167 is "Y", does this provide					N		0 171. 00	
section 1876 Medicare cost plans repo								
"Y" for yes and "N" for no in column		yes, enter the number	r or sec	tion				
1876 Medicare days in column 2. (see	instructions)			I				

	Financial Systems TAYLORVILLE MEMORAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 14-1339	Period: From 10/01/2018	u of Form CMS- Worksheet S-2 Part II	2
				To 09/30/2019	2/26/2020 1:3	
				Y/N 1,00	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	sponses. Ente	1.00 er all dates in t	2. 00 the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					
1 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	hadinning of	the cost	N		1 00
1. 00	reporting period? If yes, enter the date of the change in co					1. 00
			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare Pr	rogram? If	1. 00 N	2. 00	3. 00	2.00
	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	n 3, "V" for				
3. 00	Is the provider involved in business transactions, including	g management	Y			3. 00
	contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other relationships? (see instructions)	similar				
	rerationships? (see instructions)		Y/N	Туре	Date	
	Financial Data and Danarta		1.00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certi	fied Public	Y	A		4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" for	or Compiled,				
	or "R" for Reviewed. Submit complete copy or enter date avaicolumn 3. (see instructions) If no, see instructions.	rable in				
5.00	Are the cost report total expenses and total revenues differ		N			5. 00
	those on the filed financial statements? If yes, submit reco	nciliation.		Y/N	Legal Oper.	
				1. 00	2.00	
6. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	If ves. is th	ne provider is	S N		6.00
	the legal operator of the program?		,			
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing school and/or allied health programs approved a		l during the	N N		7. 00 8. 00
	cost reporting period? If yes, see instructions.		· ·			
9.00	Are costs claimed for Interns and Residents in an approved g program in the current cost report? If yes, see instructions		al education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated or		he current	N		10.00
11. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I	& R in an App	proved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.					1
					Y/N 1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection po			nst reporting	Y N	12.00
13.00	period? If yes, submit copy.	3	Ü			
14. 00	If line 12 is yes, were patient deductibles and/or co-paymen Bed Complement	nts waived? If	yes, see ins	structi ons.	N	14. 00
15. 00	Did total beds available change from the prior cost reporting	U .	-	ructions.	N	15. 00
		Y/N Par	t A Date	Par Y/N	t B Date	
		1.00	2.00	3. 00	4. 00	
16. 00	PS&R Data Was the cost report prepared using the PS&R Report only?	Y	12/26/2019	Y	12/26/2019	16. 00
10.00	If either column 1 or 3 is yes, enter the paid-through	,	12/20/2017	'	12/20/2017	10.00
	date of the PS&R Report used in columns 2 and 4 (see instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	N		N		17. 00
	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)					
	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	N		N		18. 00
18. 00	Inoport data for additional orallis that have been billed		I			1
18. 00	but are not included on the PS&R Report used to file this					
	but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		10 00
18. 00 19. 00	but are not included on the PS&R Report used to file this	N		N		19. 00

Heal th	Financial Systems TAYLORVILLE MEM	MORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 14-1339	Peri od: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Pre 2/26/2020 1:3	epared:	
			iption	Y/N	Y/N		
00.00	1011 11 1000		0	1.00	3.00	00.00	
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	
	report data for other: bescribe the other adjustments.	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 (EXC	EPT CHILDRENS H	(OSPLTALS)		1.00		
	Capi tal Related Cost		,				
22.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22. 00	
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprais	als made dur	ing the cost	N	23. 00	
	reporting period? If yes, see instructions.						
24. 00	Were new leases and/or amendments to existing leases enter	ed into during	this cost re	porting period?	N	24. 00	
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repor	ting period?	If was saa	N	25. 00	
25.00	instructions.	the cost repor	ting perious	ii yes, see	1 N	25.00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost reporti	na period? I	f ves. see	N	26. 00	
	instructions.		3 1	3 ,			
27. 00	Has the provider's capitalization policy changed during th	e cost reportir	ng period? If	yes, submit	N	27. 00	
	copy.						
20.00	Interest Expense				N.	1 20 00	
28. 00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	nterea into aur	ing the cost	reporting	N	28. 00	
29. 00	Did the provider have a funded depreciation account and/or	hond funds (De	ht Service R	eserve Fund)	N	29. 00	
27.00	treated as a funded depreciation account? If yes, see inst		bt belvice i	eserve runa)	.,	27.00	
30.00	Has existing debt been replaced prior to its scheduled mat		debt? If yes	, see	N	30.00	
	instructions.		,				
31. 00	Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes	, see	N	31.00	
	instructions.					-	
32. 00	Purchased Services Have changes or new agreements occurred in patient care se	rvi cos furni cho	d through or	ntractual	N	32. 00	
32.00	arrangements with suppliers of services? If yes, see instr		a tili ougii cc	iiti actuai	IN	32.00	
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competi	tive bidding? If	N	33.00	
	no, see instructions.		<u> </u>	3			
	Provi der-Based Physi ci ans						
34. 00	Are services furnished at the provider facility under an a	rrangement with	n provi der-ba	sed physi ci ans?	Υ	34. 00	
05.00	If yes, see instructions.				.,	05.00	
35. 00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		its with the	provi der-based	N	35. 00	
	phrysicians during the cost reporting period: if yes, see i	iisti ucti olis.		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 p	repared by the	home office?	Υ		37. 00	
20.00	If yes, see instructions.		£			20.00	
38.00	If line 36 is yes, was the fiscal year end of the home of			N		38. 00	
39. 00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth			., N		39. 00	
57.00	see instructions.	.c. charn compor	.s	14		57.00	
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00	
	Coot Papart Propaga Contact Information						
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	KEVIN		WELLEN		41.00	
41.00	held by the cost report preparer in columns 1, 2, and 3,	INC VIIN		VVLLLLIV		#1.00	
	respectively.						
42.00	Enter the employer/company name of the cost report	CLI FTONLARSONA	LLEN LLP			42.00	
	preparer.						
43.00	Enter the telephone number and email address of the cost	314-925-4446		KEVI N. WELLEN@C	LACONNECT. COM	43. 00	
	report preparer in columns 1 and 2, respectively.	1				II	

Heal th	Financial Systems TAYLORVILLE N	1EMC	ORIAL HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1339			Worksheet S-2	
				To	rom 10/01/2018 b 09/30/2019	Part II Date/Time Pre 2/26/2020 1:3	
			3. 00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position		DI RECTOR				41.00
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
42.00	Enter the employer/company name of the cost report						42.00
	preparer.						
43.00	Enter the telephone number and email address of the cost						43.00
	report preparer in columns 1 and 2, respectively.						
	report preparer in columns 1 and 2, respectively.	I		ļ			l

| Period: | Worksheet S-3 | From 10/01/2018 | Part | To 09/30/2019 | Date/Time Prepared: Health Financial Systems TAYLORVILLE MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CO Provider CCN: 14-1339

					1	To 09/30/2019	Date/Time Prep 2/26/2020 1:3	
							I/P Days / 0/P	7 piii
							Visits / Trips	
	Component	Worksheet A	No. of Be	eds	Bed Days	CAH Hours	Title V	
	·	Line Number			Avai I abl e			
		1. 00	2. 00		3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		25	9, 125	51, 748. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO I RF Subprovi der						_	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			25	9, 125	51, 748. 00	0	7. 00
0.00	beds) (see instructions) INTENSIVE CARE UNIT							8. 00
8. 00 9. 00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							9. 00 10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							10.00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY							13. 00
14. 00	Total (see instructions)			25	9, 125	51, 748. 00	0	14. 00
15. 00	CAH visits			23	7, 120	31, 740.00	0	15. 00
16. 00	SUBPROVI DER - I PF						Ĭ	16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							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	HOSPI CE							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)			25				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							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	()		32. 00
32. 01	Total ancillary labor & delivery room							32. 01
22.00	outpatient days (see instructions)			-				22.00
33. 00	LTCH non-covered days							33. 00
33. U I	LTCH site neutral days and discharges			- 1				33. 01

Health Financial Systems TAYLORVILLE MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CO Provider CCN: 14-1339

				'	0 097 307 2019	2/26/2020 1:3	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	, piii
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	r Production			Pati ents	& Residents	Payrol I	
		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)	1, 653	36	2, 155			1. 00
2.00	HMO and other (see instructions)	178	0				2. 00
3.00	HMO I PF Subprovi der	o	0				3.00
4.00	HMO IRF Subprovider	o	o				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	2, 020	o	2, 659			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		o	165			6.00
7. 00	Total Adults and Peds. (exclude observation	3, 673	36	4, 979			7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	0,070		.,,,,,			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)	3, 673	36	4, 979	0.00	263. 15	1
15. 00	CAH visits	3,073	30	4, 7/7	0.00	203. 13	15. 00
16. 00	SUBPROVI DER - I PF	U	U	U			16. 00
17. 00	SUBPROVIDER - I FF	-					17. 00
18. 00	SUBPROVI DER	-					18.00
19. 00	SKILLED NURSING FACILITY	-					19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						20.00
							1
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE			0			24.00
24. 10	HOSPICE (non-distinct part)			U			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC				0.00	0.00	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
27. 00	Total (sum of lines 14-26)		_	0.50	0.00	263. 15	
28. 00	Observation Bed Days		5	253			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			12			30.00
31. 00	Employee discount days - IRF			0			31. 00
32. 00	Labor & delivery days (see instructions)	0	0	0			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

Health Financial Systems TAYLORVILLE MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CO Provider CCN: 14-1339

| Peri od: | Worksheet S-3 | From 10/01/2018 | Part | To 09/30/2019 | Date/Time Prepared:

				10	09/30/2019	Date/IIme Pre 2/26/2020 1:3	
		Full Time	<u>'</u>	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		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		0	425	13	610	1. 00
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			35	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						7. 00
8. 00	beds) (see instructions) 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	425	13	610	14.00
15.00	CAH visits						15.00
16.00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						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	HOSPI CE						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	Ambul ance Tri ps						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						32. 01
	outpatient days (see instructions)			_			
	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01

Heal th	Financial Systems TAYLORVILLE MEMORIA	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10
	TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1339	Peri od:	Worksheet S-10	
			From 10/01/2018	D-+- /T: D	
			To 09/30/2019	Date/Time Prep 2/26/2020 1:3	
				1 00	
	Uncompensated and indigent care cost computation			1. 00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by line 202 colum	n 8)	0. 312433	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			2, 466, 816	2. 00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Υ	3. 00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemen		ai d?	N	4. 00
5. 00 6. 00	If line 4 is no, then enter DSH and/or supplemental payments f Medicaid charges	rom Medicald		2, 259, 722	5. 00 6. 00
7. 00	Medicaid coat (line 1 times line 6)			23, 309, 168 7, 282, 553	
8. 00	Difference between net revenue and costs for Medicaid program	(line 7 minus sum of li	nes 2 and 5: if	2, 556, 015	1
	< zero then enter zero)	`	,	_,,,	
	Children's Health Insurance Program (CHIP) (see instructions for	or each line)			
9.00	Net revenue from stand-alone CHIP			22, 561	9. 00
10.00	Stand-allone CHIP charges			233, 651	
11.00	Stand-alone CHIP cost (line 1 times line 10)	(line 11 minus line O.	if . zono thon	73, 000	
12. 00	Difference between net revenue and costs for stand-alone CHIP enter zero)	(Title II militus IIIle 9;	ii < Zero then	50, 439	12. 00
	Other state or local government indigent care program (see ins	tructions for each line)		
13.00	Net revenue from state or local indigent care program (Not inc			0	13. 00
14. 00	Charges for patients covered under state or local indigent car	e program (Not included	in lines 6 or	0	14. 00
45.00	10)	4)			45.00
15. 00 16. 00	State or local indigent care program cost (line 1 times line 1 Difference between net revenue and costs for state or local in		no 1E minuo Lino	0	15. 00 16. 00
10.00	13; if < zero then enter zero)	digent care program (ii	ne is illinus iine	U	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CH	IP and state/local indi	gent care program	ns (see	
17. 00	Instructions for each line) Private grants, donations, or endowment income restricted to f	unding charity care		0	17. 00
18. 00	Government grants, appropriations or transfers for support of	3		0	1
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and loca		s (sum of lines	2, 606, 454	
	8, 12 and 16)				
		Uni nsured		Total (col. 1	
		patients 1,00	pati ents 2.00	+ col . 2) 3.00	
	Uncompensated Care (see instructions for each line)	100	2.00	0.00	
20.00	Charity care charges and uninsured discounts for the entire fa	cility 424, 8	69, 054	493, 904	20. 00
	(see instructions)			004 704	
21. 00	Cost of patients approved for charity care and uninsured disco instructions)	unts (see 132,7	69, 054	201, 791	21.00
22. 00	Payments received from patients for amounts previously written	off as 8, 1	24 0	8 124	22. 00
22.00	charity care	0, 1		0, 121	22.00
23. 00	Cost of charity care (line 21 minus line 22)	124, 6	69, 054	193, 667	23. 00
				1 00	
24 00	Does the amount on line 20 column 2, include charges for patie	nt days beyond a Length	of stay limit	1. 00 N	24. 00
24.00	imposed on patients covered by Medicaid or other indigent care		or stay rriiir t	14	24.00
25. 00	If line 24 is yes, enter the charges for patient days beyond t stay limit		m's length of	0	25. 00
26. 00	Total bad debt expense for the entire hospital complex (see in	structi ons)		2, 584, 844	26. 00
27. 00	Medicare reimbursable bad debts for the entire hospital comple	•		796, 073	27. 00
27. 01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1, 224, 728	ı
28. 00	Non-Medicare bad debt expense (see instructions)			1, 360, 116	1
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	pense (see Instructions)	853, 600	
30. 00 31. 00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)		1, 047, 267 3, 653, 721	
51.00	Trotal an ormbursed and uncompensated care cost (Trile 17 prus 1	1110 00)		5,055,721	1 31.00

Health Financial Systems 1	AYLORVILLE MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		Peri od:	Worksheet A	
				rom 10/01/2018		
				Γο 09/30/2019		
Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	2/26/2020 1: 3 Reclassified	/ pm
cost center bescription	Sal al Les	other	+ col . 2)	ons (See A-6)	Tri al Balance	
			+ (01. 2)	Olis (See A-0)	(col. 3 +-	
					col . 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
1. 00 00100 CAP REL COSTS-BLDG & FLXT		2, 732, 690	2, 732, 69	524, 613	3, 257, 303	1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP		1, 138, 416	1, 138, 41		1, 209, 705	2. 00
3. 00 00300 OTHER CAP REL COSTS		.,,		0	0	3. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	599, 174	4, 397, 706	4, 996, 880	-73, 280	4, 923, 600	4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	2, 374, 922	4, 564, 960	6, 939, 88		6, 917, 429	5. 00
7. 00 00700 OPERATION OF PLANT	771, 892	1, 001, 773	1, 773, 66		1, 773, 665	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	18, 672	133, 621	152, 29		152, 293	8. 00
9. 00 00900 HOUSEKEEPI NG	375, 331	78, 899	454, 230	1	454, 230	9. 00
10. 00 01000 DI ETARY	410, 243	399, 278	809, 52	1	214, 120	10.00
11. 00 01100 CAFETERI A	410, 243	377, 270	007, 32	595, 401	595, 401	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	745, 606	76, 393	821, 99		821, 999	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	159, 004	103, 165	262, 16		261, 396	14. 00
15. 00 01500 PHARMACY	454, 665	1, 182, 012	1, 636, 67		524, 409	15. 00
16. 00 01600 MEDICAL RECORDS & LI BRARY	475, 318	45, 290	520, 60		520, 608	16. 00
17. 00 01700 SOCIAL SERVICE	63, 706	4, 541	68, 24	1	68, 247	17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	666, 435	28, 082	694, 51		767, 797	19. 00
INPATIENT ROUTINE SERVICE COST CENTERS	000, 433	20, 002	094, 31	73, 200	707, 797	19.00
30. 00 03000 ADULTS & PEDI ATRI CS	2, 352, 557	615, 998	2, 968, 55	-82	2, 968, 473	30. 00
ANCI LLARY SERVI CE COST CENTERS	2, 352, 557	015, 770	2, 700, 55	5 -02	2, 700, 473	30.00
50. 00 05000 OPERATING ROOM	572, 123	925, 828	1, 497, 95	1 -409, 633	1, 088, 318	50. 00
53. 00 05300 OFERATTING ROOM 53. 00 05300 ANESTHESI OLOGY	372, 123	246, 869	246, 86		237, 597	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 185, 592	725, 050	1, 910, 64		1, 910, 343	54. 00
60. 00 06000 LABORATORY	839, 582	1, 155, 107	1, 910, 64.		1, 910, 343	60.00
64. 00 06400 NTRAVENOUS THERAPY	039, 302	1, 155, 107		0	1, 994, 025	64. 00
65. 00 06500 RESPI RATORY THERAPY	519, 270	103, 670	622, 940	۷۱ ۲	575, 232	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 113, 193	122, 711	1, 235, 90		1, 235, 904	66. 00
67. 00 06700 OCCUPATIONAL THERAPY	296, 976	26, 681	323, 65		323, 657	67. 00
68. 00 06800 SPEECH PATHOLOGY	124, 647	12, 051	136, 69		136, 698	68. 00
69. 00 06900 SPEECH PATHOLOGY	178, 651	12, 031 26, 760	205, 41		205, 411	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	170,031	26, 760		123, 844	123, 844	71.00
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			· ·	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		358, 750	358, 750	72.00
73. 00 07300 DROGS CHARGED TO PATTENTS 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	185, 719	1/4 205	349, 92	1, 112, 128	1, 112, 128	76.00
	185, 719	164, 205		0	349, 924	76. 00 76. 01
76. 01 03950 DI ABETI C EDUCATI ON OUTPATI ENT SERVI CE COST CENTERS	l ol	U		<u> </u>	0	76.01
91. 00 09100 EMERGENCY	1, 694, 414	2, 964, 209	4, 658, 623	-14, 623	4, 644, 000	91. 00
	1, 694, 414	2, 964, 209	4, 058, 02	- 14, 023	4, 644, 000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92. 00
113. 00 11300 I NTEREST EXPENSE		E72 440	E70 444	572 440	^	112 00
	14 177 400	573, 449	573, 44			113.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	16, 177, 692	23, 549, 414	39, 727, 10	6 0	39, 727, 106	118.00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		ما			^	190. 00
	0	0		0 0		
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	1 -1	252	25:			192.00
200.00 TOTAL (SUM OF LINES 118 through 199)	16, 177, 692	23, 549, 666	39, 727, 35	8 0	39, 727, 358	J∠UU. UU

Provider CCN: 14-1339

| Period: | Worksheet A | From 10/01/2018 | To 09/30/2019 | Date/Time Prepared: 2/26/2020 1:37 pm

Cost Center Description						2/2	6/2020 1:37 pm
CENERAL SERVICE COST CENTERS		Cost Center Description	Adjustments	Net Expenses			
SENERAL SERVICE COST CENTERS			(See A-8)	For Allocation	1		
1.00 00100 CAP REL COSTS-BUBLE ON FIXT -1,827,510 1,429,793 2,00 3.00 3.00 0.0300 CAP REL COSTS 0 2,30,007 2,39,912 2,00 0.0300 0.0300 CAP REL COSTS 0 0 3.00 0.0300 CAP REL COSTS 0 0 3.00 0.0300 CAP REL COSTS 0 0 0.0500 CAP REL COSTS 0 0.0500 CAP REL COSTS 0.00500 CAP REL COST 0.005000 CAP REL COST 0.00500 CAP REL COST 0.005000			6. 00	7. 00			
2.00							
3.00 00300 OTHER CAP REL COSTS	1.00	00100 CAP REL COSTS-BLDG & FIXT	-1, 827, 510	1, 429, 793	3		1. 00
4 .00 00400 EMPLOYEE BENEFITS DEPARTMENT -270, 883 4, 652, 777 4, 00 7.00 00700 00FERATION OF PLANT -870, 781 -10, 401 1, 763, 264 7.00 8.00 00800 LAINDRY & LINEN SERVICE 0 454, 230 9.00 09900 HOUSEKEEPI NG 0 454, 230 9.00 09900 HOUSEKEEPI NG 0 454, 230 9.00 11.00 1	2.00	00200 CAP REL COSTS-MVBLE EQUIP	30, 207	1, 239, 912	2		2. 00
5. 00 OSOOO ADMINISTRATIVE & GENERAL -857, 533 6, 059, 846 7. 00 7. 00 7. 00 OSOOO OPERATION OF PLANT -10, 401 1, 763, 264 7. 00 7. 00 0	3.00	00300 OTHER CAP REL COSTS	0	(3. 00
7. 00 7. 00	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-270, 883	4, 652, 717	7		4.00
7. 00 7. 00	5.00	00500 ADMINISTRATIVE & GENERAL	-857, 583	6, 059, 846	5		5.00
8. 00 00800 LAUNDRY & LINEN SERVICE 0 0 152, 293 0, 00 10. 00 10. 00 10100 DIETARY 0 0 214, 120 11. 00 11. 00 111. 00	7 00				1		7 00
9. 00 00900 NOUSEKEEPING 0 454, 230 9. 00 10. 00 10100 DIETARY 0 0 214, 120 10. 00 11. 00 01100 DIETARY 0 0 214, 120 11. 00 11. 00 01100 CAFETERIA			l		1		l
10. 00 10.00 10.00 10.00 10.00 17.00 17.00 10.00 11.00 10.00 11.			I -				l
11. 00 01100 CAFETERIA			I -				l l
13. 00 01300 NURSI NG ADMIN ISTRATI ON 0 821, 999 13. 00							l l
14. 00 01400 CENTRAL SERVICES & SUPPLY 0 261, 396 14. 00 15. 00 01500 PHARMACY 0 524, 409 15. 00 16. 00 01600 MEDI CAL RECORDS & LI BRARY -7, 835 512, 773 16. 00 17. 00 01700 SOCI AL SERVICE 0 68, 247 17. 00 17. 00 17. 00 17. 00 01700 SOCI AL SERVICE 0 68, 247 17. 00 17							l l
15. 00 15.			·				
16. 00			·		1		l l
17. 00					1		l l
19. 00 01900 NONPHYSICIAM ANESTHETISTS -767,797 0 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 1			-7,835		1		l
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 30			0				l
30.00	19.00		-767,797		ار		19.00
ANCILLARY SERVICE COST CENTERS 50.00							
50.00			-222, 000	2, 746, 473	3		30.00
53. 00 05300 ANESTHESI OLOGY -55, 832 181, 765 53. 00 54. 00 RODI OLOGY-DI AGNOSTI C 0 1, 910, 343 54. 00 60. 00 06000 LABORATORY 0 1, 994, 625 60. 00 64. 00 64. 00 64. 00 64. 00 64. 00 65. 00 665. 00 665. 00 665. 00 665. 00 66600 PHYSI CAL THERAPY 0 1, 235, 904 66. 00 66. 00 66600 PHYSI CAL THERAPY 0 323, 657 67. 00 670. 00 60600 PHYSI CAL THERAPY 0 323, 657 67. 00 68. 00 688. 00 69800 SPEECH PATHOLOGY 0 136, 698 68. 00 69900 ELECTROCARDI OLOGY -528 204, 883 69. 00 6900 ELECTROCARDI OLOGY -528 204, 883 69. 00 67. 00 671.00 ELECTROCARDI OLOGY -528 204, 883 69. 00 67. 00 6				1 050 (76	J		50.00
S4.00			•		1		· · · · · · · · · · · · · · · · · · ·
60. 00		l l	· ·		1		
64. 00			_		1		
65. 00			0		1		· · · · · · · · · · · · · · · · · · ·
66. 00 06600 PHYSI CAL THERAPY 0 1, 235, 904 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 323, 657 67. 00 68. 00 06800 SPECH PATHOLOGY 0 136, 698 68. 00 06900 ELECTROCARDI OLOGY -528 204, 883 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 123, 844 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 0 358, 750 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 358, 750 72. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 349, 924 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 349, 924 76. 00 00 00 00 00 00 00 00			0		-1		· · · · · · · · · · · · · · · · · · ·
67. 00							· · · · · · · · · · · · · · · · · · ·
68. 00				,			· · · · · · · · · · · · · · · · · · ·
69. 00 06900 ELECTROCARDI OLOGY -528 204, 883 69. 00 71. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 123, 844 71. 00 72. 00 72. 00 72. 00 72. 00 73.			0				
71. 00	68.00	06800 SPEECH PATHOLOGY	_		3		68. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 358, 750 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 1, 112, 128 73. 00 76. 00 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 349, 924 76. 00 0 0 0 0 0 0 0 0 0	69.00	06900 ELECTROCARDI OLOGY	-528	204, 883	3		69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 1, 112, 128 73. 00 76. 00 349, 924 76. 00 349, 924 76. 00 76. 01 03950 DI ABETI C EDUCATI ON 0 0 0 0 0 0 0 0 0	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	123, 844	1		71. 00
76. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	358, 750			72. 00
76. 01 03950 DI ABETI C EDUCATI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 112, 128	3		73. 00
OUTPATI ENT SERVI CE COST CENTERS 91. 00 92. 00 9	76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	349, 924	1		76. 00
91. 00	76. 01	03950 DIABETIC EDUCATION	0	(76. 01
92. 00 92. 00 9200 0BSERVATI ON BEDS (NON-DISTINCT PART 92. 00		OUTPATIENT SERVICE COST CENTERS					
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	91.00	09100 EMERGENCY	-2, 348, 859	2, 295, 141	1		91. 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					92. 00
113. 00 118. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
NONREI MBURSABLE COST CENTERS 0 0 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 252 192.00	113.00		0	(113. 00
NONREI MBURSABLE COST CENTERS 0 0 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 252 192.00	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-6, 546, 626	33, 180, 480	ol		118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 252 192. 00					-		
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 252 192. 00			0				190. 00
					1		
			-6, 546, 626	l .	1		· · · · · · · · · · · · · · · · · · ·
							1

					From 10/01/2018 To 09/30/2019	Date/Time Prepar 2/26/2020 1:37 p	
		Increases				2/20/2020 1.3/	JIII
	Cost Center	Li ne #	Sal ary	Other			
	2. 00	3.00	4.00	5. 00			
	A - CAFETERIA EXPENSE						
1.00	CAFETERI A	11. 00	301, 733	293, 668			1.00
	0		301, 733	293, 668			
	B - DRUG EXPENSE						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1, 112, 128			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		0.00	0	0			5.00
6.00		0.00	0	0			6.00
7.00		0.00	0_	0			7.00
	0		0	1, 112, 128			
	C - IMPLANTS & MEDICAL SUPPLI	ES					
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	123, 844			1. 00
2. 00	IMPL. DEV. CHARGED TO PATIENTS	72. 00	O	358, 750			2. 00
3.00		0.00	o	0			3.00
4.00		0.00	0	0			4. 00
5.00		0.00	0	0			5.00
6. 00		0.00	0	0			6. 00
7. 00		0.00	0	0			7. 00
		— — +	— — j	482, 594			
	D - PROPERTY INSURANCE		-1	,			
1.00	OTHER CAP REL COSTS	3.00	0	22, 453			1. 00
			— — 	22, 453			
	E - INTEREST EXPENSE		<u>'</u>				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	610, 158			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	O	61, 393			2.00
				671, 551			
	F - BOND AMORTIZATION EXPENSE						
1.00	INTEREST EXPENSE	113. 00	0	98, 102			1.00
				98, 102			
	G - CRNA BENEFITS						
1.00	NONPHYSICIAN ANESTHETISTS	19. 00	0	73, 280			1.00
	0			73, 280			
500.00	Grand Total: Increases		301, 733	2, 753, 776		50	00.00

					1	Го 09/30/2019	Date/Time Prepared: 2/26/2020 1:37 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8.00	9. 00	10.00		
	A - CAFETERIA EXPENSE	<u> </u>					
1.00	DI ETARY	10.00	301, 733	293, 668	0		1. 00
			301, 733	293, 668			
	B - DRUG EXPENSE		<u>. </u>				
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	18	0		1.00
2.00	PHARMACY	15. 00	o	1, 111, 394	0		2. 00
3.00	ADULTS & PEDIATRICS	30.00	o	82	0		3.00
4.00	OPERATING ROOM	50.00	o	203	0		4. 00
5.00	LABORATORY	60.00	o	64	0		5. 00
6.00	RESPI RATORY THERAPY	65.00	o	32	0		6. 00
7.00	EMERGENCY	91.00	o	335	0		7. 00
				1, 112, 128			
	C - IMPLANTS & MEDICAL SUPPLI	ES	<u>.</u>				
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	755	0		1.00
2.00	PHARMACY	15. 00	О	874	0		2. 00
3.00	OPERATING ROOM	50.00	О	409, 430	0		3.00
4.00	ANESTHESI OLOGY	53.00	o	9, 272	0		4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	О	299	0		5. 00
6.00	RESPI RATORY THERAPY	65.00	О	47, 676	0		6. 00
7.00	EMERGENCY	91.00	О	14, 288	0		7. 00
				482, 594			
	D - PROPERTY INSURANCE	<u> </u>				<u> </u>	
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	22, 453	0		1.00
				22, 453			
	E - INTEREST EXPENSE	<u> </u>		·		<u> </u>	
1.00	INTEREST EXPENSE	113.00	0	671, 551	11		1.00
2.00		0.00	О	0	11		2. 00
				671, 551			
	F - BOND AMORTIZATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	98, 102	14		1.00
				98, 102			
	G - CRNA BENEFITS		<u>'</u>	·			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	73, 280	0		1.00
				73, 280			
500.00	Grand Total: Decreases		301, 733	2, 753, 776			500. 00
	'	'		•	1	1	"

					o 09/30/2019		
				Acqui si ti ons		2/26/2020 1:3	/ pm
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances	i ui chases	Donation	Total	Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		2.00	0.00		0.00	
1.00	Land	948, 070	0	C	0	0	1. 00
2.00	Land Improvements	3, 045, 962	1, 102, 068	C	1, 102, 068	0	2. 00
3.00	Buildings and Fixtures	25, 561, 465	343, 426	C	343, 426	0	3. 00
4.00	Building Improvements	0	o	C	0	0	4. 00
5.00	Fixed Equipment	0	o	C	0	0	5. 00
6.00	Movable Equipment	22, 877, 705	1, 603, 842	C	1, 603, 842	51, 625	6.00
7.00	HIT designated Assets	0	0	C	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	52, 433, 202	3, 049, 336	C	3, 049, 336	51, 625	8. 00
9.00	Reconciling Items	-5, 839, 415	-22, 772, 116	C	-22, 772, 116	0	9. 00
10.00	Total (line 8 minus line 9)	58, 272, 617	25, 821, 452	C	25, 821, 452	51, 625	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		_1				
1.00	Land	948, 070	0				1. 00
2.00	Land Improvements	4, 148, 030	0				2. 00
3.00	Buildings and Fixtures	25, 904, 891	0				3.00
4.00	Building Improvements	0	0				4. 00
5.00	Fi xed Equi pment	0 4 400 000	0				5. 00
6.00	Movable Equipment	24, 429, 922	0				6. 00
7.00	HIT designated Assets	FF 420 013	0				7. 00
8. 00 9. 00	Subtotal (sum of lines 1-7)	55, 430, 913	0				8. 00 9. 00
9. 00 10. 00	Reconciling Items Total (line 8 minus line 9)	-28, 611, 531 84, 042, 444	0				9. 00 10. 00
10.00	Tiotal (Title 6 millius Title 9)	04, 042, 444	υĮ			ļ	10.00

Heal th	Financial Systems	TAYLORVILLE MEMO	ORIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 14-1339	Peri od: From 10/01/2018 To 09/30/2019		pared:
			SL	JMMARY OF CAP	TAL		
	Cost Center Description	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 WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	2, 732, 690	0		0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 138, 416	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	3, 871, 106	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2, 732, 690				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 138, 416				2. 00
3. 00	Total (sum of lines 1-2)	0	3, 871, 106				3. 00

Heal th	n Financial Systems T	AYLORVILLE MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od:	Worksheet A-7	
					From 10/01/2018 To 09/30/2019		nared:
					07/30/2017	2/26/2020 1:3	
		COME	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
		0 4 1			D 11 (
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance	
			Leases	(col . 1 - col	,		
				2)			
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	CAP REL COSTS-BLDG & FLXT	31, 000, 991	0	31, 000, 99		12, 557	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	24, 429, 922	l	24, 429, 92		9, 896	2. 00
3.00	Total (sum of lines 1-2)	55, 430, 913		55, 430, 91			3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART III DECONOLILIATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CE		0	10 55	1 407 150	0	1. 00
2. 00	CAP REL COSTS-BLDG & FIXI	0		12, 55 9, 89			2. 00
3. 00	Total (sum of lines 1-2)	0	1	22, 45		0	3. 00
3.00	Total (Suil of Titles 1-2)	U		JMMARY OF CAPI		U	3.00
			30	DIVINANT OF CALL	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
	DART LLL DECONOLILATION OF CARLEY STATES	11.00	12. 00	13. 00	14. 00	15. 00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS CE		40.553		10.070	4 400 700	4 00
1.00	CAP REL COSTS-BLDG & FLXT CAP REL COSTS-MVBLE EQUIP	0			10, 078		1. 00 2. 00
2. 00 3. 00	Total (sum of lines 1-2)	0			0 10, 078	1, 239, 912 2, 669, 705	
3.00	Total (Suill of Titles 1-2)	0	22, 453	'	J 10, 078	[∠, 009, 705]	3. 00

ADJUSTMENTS TO EXPENSES Provider CCN: 14-1339 Peri od: Worksheet A-8 From 10/01/2018 09/30/2019 Date/Time Prepared: 2/26/2020 1:37 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL -610, 158 CAP REL COSTS-BLDG & FLXT 1. 00 В 1.00 11 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL В -61, 393 CAP REL COSTS-MVBLE EQUIP 2.00 11 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other В -7, 453 ADMINI STRATI VE & GENERAL 5.00 3.00 (chapter 2) Trade, quantity, and time 4 00 В -1, 430 ADMINISTRATIVE & GENERAL 4 00 5 00 discounts (chapter 8) 5.00 Refunds and rebates of 0 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay -4, 933 ADMI NI STRATI VE & GENERAL 7.00 5.00 7.00 Α stations excluded) (chapter 21) 8.00 Tel evi si on and radio servi ce -10, 401 OPERATION OF PLANT 7.00 8.00 Α (chapter 21) Parking lot (chapter 21) 9.00 9.00 0.00 -2 656 337 10.00 Provider-based physician A-8-2 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 327, 333 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests В -177, 959 CAFETERI A 11.00 14.00 Rental of quarters to employee 15.00 15.00 0.00 and others Sale of medical and surgical 16.00 0 0.00 16.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 0 17.00 pati ents -7,835 MEDICAL RECORDS & LIBRARY 18.00 Sale of medical records and В 16.00 18.00 abstracts Nursing and allied health 19 00 19 00 0 00 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 Income from imposition of 21.00 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0.00 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24 00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review 0 *** Cost Center Deleted *** 114.00 25.00 physicians' compensation (chapter 21) Depreciation - CAP REL -1, 340, 414 CAP REL COSTS-BLDG & FIXT 26.00 Α 1.00 26.00 COSTS-BLDG & FLXT Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 27.00 2.00 27.00 COSTS-MVBLE EQUIP 28.00 -767, 797 NONPHYSI CI AN ANESTHETI STS 19.00 28.00 Non-physician Anesthetist Α Physicians' assistant 29 00 29.00 0.00 30.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see 30.99 OADULTS & PEDIATRICS 30.00 30.99 instructions) 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0.00 32.00 Depreciation and Interest 33.00 MISC INCOME - A&G

-7, 130 ADMINISTRATIVE & GENERAL

5.00

0 33.00

В

Heal th	n Financial Systems	T	AYLORVILLE MEMO	DRIAL HOSPITAL	In Lie	eu of Form CMS-2	2552-10
ADJUS	TMENTS TO EXPENSES				eri od:	Worksheet A-8	
					rom 10/01/2018 o 09/30/2019	Date/Time Pre 2/26/2020 1:3	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Contor Doscription	Paci c/Codo (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	Cost Center Description	Basi s/Code (2)					
	THE OF THEORET SEE	1.00	2.00	3. 00	4. 00	5. 00	
33. 01	MISC INCOME - EKG						
		В		ELECTROCARDI OLOGY	69. 00	l e	33. 01
33. 02		A		ELECTROCARDI OLOGY ADMI NI STRATI VE & GENERAL	69. 00 5. 00	l e	33. 01 33. 02
33. 02 33. 03	PROVI DER TAX		-1, 272, 278			0	
	PROVIDER TAX ADVERTISING EXPENSE	Ā	-1, 272, 278 -76, 671	ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 03	PROVIDER TAX ADVERTISING EXPENSE	A A	-1, 272, 278 -76, 671 -18, 766	ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0 0 0	33. 02 33. 03
33. 03 34. 00	PROVIDER TAX ADVERTISING EXPENSE LOBBYING EXPENSE PHYSICIAN LOAN FORGIVENESS	A A A	-1, 272, 278 -76, 671 -18, 766 -4, 425	ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00 5. 00	0 0 0 0	33. 02 33. 03 34. 00 34. 01
33. 03 34. 00 34. 01	PROVIDER TAX ADVERTISING EXPENSE LOBBYING EXPENSE PHYSICIAN LOAN FORGIVENESS LOSS ON BOND REFUNDING	A A A	-1, 272, 278 -76, 671 -18, 766 -4, 425 108, 180	ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5. 00 5. 00 5. 00 5. 00	0 0 0 0 14	33. 02 33. 03 34. 00 34. 01
33. 03 34. 00 34. 01 35. 00 36. 00	PROVIDER TAX ADVERTISING EXPENSE LOBBYING EXPENSE PHYSICIAN LOAN FORGIVENESS LOSS ON BOND REFUNDING	A A A A	-1, 272, 278 -76, 671 -18, 766 -4, 425 108, 180 25, 422	ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL CAP REL COSTS-BLDG & FIXT	5. 00 5. 00 5. 00 5. 00 1. 00 5. 00	0 0 0 0 0 14	33. 02 33. 03 34. 00 34. 01 35. 00

-6, 546, 626

50.00

column 6, line 200.)

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

50.00 TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

- 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

Provider CCN: 14-1339

Worksheet A-8-1

From 10/01/2018 OFFICE COSTS 09/30/2019 Date/Time Prepared: 2/26/2020 1:37 pm Li ne No. Cost Center Expense I tems Amount of Amount Allowable Cost Included in

					Wks. A, column	
					5	
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HO NEW CAPITAL - BLDG	14, 569	0	1.00
2.00	2. 00	CAP REL COSTS-MVBLE EQUIP	HO NEW CAPITAL - MME	1, 110	l ol	2. 00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HO OTHER CAPITAL - BLDG	313	ol	3.00
4.00	2. 00	CAP REL COSTS-MVBLE EQUIP	HO OTHER CAPITAL - MME	90, 490	l o	4.00
4.01	5. 00	ADMINISTRATIVE & GENERAL	HO INTEREST EXPENSE	7, 453	l ol	4. 01
4.02	5. 00	ADMINISTRATIVE & GENERAL	HO MANAGEMENT OPERATING	1, 738, 904	1, 236, 276	4. 02
4.03	4. 00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	2, 517, 142	2, 806, 372	4. 03
4.04	5. 00	ADMINISTRATIVE & GENERAL	A&G ITEMS - MMC	9, 441	9, 441	4. 04
5.00	TOTALS (sum of lines 1-4).			4, 379, 422	4, 052, 089	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					1

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

nas no	been posted to worksheet A,	cor anni is i aria, or 2, the amoun	it dilowabi e sii	eara se mareatea m corami i	or this part.	
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1. 00	2.00	3.00	4. 00	5. 00	
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			
	1.00	2.00	Ownershi p 3.00		Ownershi p	

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII

6.00	В	O. OO MEMORI AL HEALTH 100. OC	6. 00
7.00	В	O. OO MEMORIAL MD CTR O. OC	7. 00
8.00	В	0. OO ABRAHAM LI NCOLN 0. OO	8. 00
9.00	В	0. OO MEMORI AL VNA 0. OO	9. 00
10.00	В	0. 00 PASSAVANT 0. 00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (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 organi zati on.
- 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 provi der

Heal th	Financial Syste	ems		TAYLORVI LL	E MEMORI	AL HOSPITA	L		In Lie	u of Form CMS-	2552-10
STATEME	NT OF COSTS OF	SERVICES FRO	M RELATED	ORGANIZATIONS AN	ID HOME	Provi der	CCN:	14-1339	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS								From 10/01/2018		
									To 09/30/2019	Date/Time Pre 2/26/2020 1:3	epared:
	Net	Wkst. A-7 Ref	,						L	2/26/2020 1:3	7 DIII
		WKSt. A-7 Kei	•								
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6. 00	7. 00									
	A. COSTS INCUR	RED AND ADJUS	TMENTS RE	QUI RED AS A RESUL	T OF TRA	NSACTI ONS	WI TH	RELATED 0	RGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:									
1.00	14, 569		9								1.00
2.00	1, 110		9								2.00
3.00	313		9								3.00
4.00	90, 490		9								4. 00
4. 01	7, 453		o								4. 01
4 02	502 628		ol								4 02

* 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.

4.03

4.04

5 00

nas i	iot been posted to worksheet A,	cordinas i diazor 2, the amount arrowable should be mareated in cordina 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming

i ei ilibui	erilibut Sellert under titte XVIII.								
6.00	MANAGEMENT HO	6.00							
7.00	HOSPI TAL	7.00							
8.00	HOSPI TAL	8.00							
9.00	HOME HEALTH	9.00							
10.00	HOSPI TAL	10.00							
100.00		100.00							

(1) Use the following symbols to indicate interrelationship to related organizations:

0

0

4.03

4.04

5.00

-289, 230

327 333

- 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.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT In Lieu of Form CMS-2552-10
Worksheet A-8-2 Peri od: From 10/01/2018 Provider CCN: 14-1339

						To 09/30/2019		epared: 37 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
					'		Hours	
	1.00	2.00	3. 00	4.00	5. 00	6. 00	7. 00	
1.00	30.00	ADULTS & PEDIATRICS	222, 000	222, 00	0 0	0	0	1. 00
2.00	50.00	OPERATING ROOM	29, 646	29, 64	6 0	0	0	2. 00
3.00	53.00	ANESTHESI OLOGY	55, 832	55, 83	2 0	0	0	3. 00
4.00	91.00	EMERGENCY	2, 605, 794	2, 348, 85	9 256, 935	0	0	4. 00
5.00	0.00		0		o o	0	0	5.00
6.00	0.00		0		o c	0	0	6. 00
7. 00	0.00		0		o c	0	0	1
8. 00	0.00		0		o c	0	0	8. 00
9. 00	0.00		0		o c	0	0	9. 00
10.00	0.00		0		o c	0	0	10.00
200.00			2, 913, 272	2, 656, 33	7 256, 935		0	1
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RC	E Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00		ADULTS & PEDIATRICS	0		0 0	0	0	1. 00
2.00		OPERATING ROOM	0		0 0	0	0	2. 00
3.00		ANESTHESI OLOGY	0		0 0	0	0	3. 00
4.00	91.00	EMERGENCY	0		0 0	0	0	4. 00
5.00	0.00		0		0 0	0	0	5. 00
6.00	0.00		0		0 0	0	0	6. 00
7.00	0.00		0		0 0	0	0	7. 00
8.00	0.00		0		0 0	0	0	8. 00
9.00	0.00		0		0 0	0	0	9. 00
10.00	0.00		0		0 0	0	0	10.00
200.00			0		0 0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE		Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00		14	1/ 00	47.00	10.00		
1 00	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		1.00
1.00		ADULTS & PEDIATRICS	0		0 0	,		1.00
2.00		OPERATI NG ROOM	0		0 0	27,010		2.00
3.00		ANESTHESI OLOGY	0		0	55, 832		3. 00
4.00		EMERGENCY	0			2, 348, 859		4. 00
5.00	0.00		0		O O	0		5. 00
6.00	0.00		0		O O	0		6. 00
7.00	0.00		0		0	0		7. 00
8. 00	0.00		0		O C	0	1	8. 00
9. 00	0. 00		0		0 0	0	1	9. 00
10. 00	0. 00		0		0	0	1	10.00
200. 00			0		0 0	2, 656, 337	I	200. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1339 Peri od: Worksheet B From 10/01/2018 Part I Date/Time Prepared: 09/30/2019 2/26/2020 1:37 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1, 429, 793 1, 429, 793 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 1, 239, 912 1, 239, 912 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4, 652, 717 4, 656, 375 4.00 3,658 C 00500 ADMINISTRATIVE & GENERAL 409, 587 7, 455, 366 5 00 6, 059, 846 244, 350 741, 583 5 00 7.00 00700 OPERATION OF PLANT 1, 763, 264 460, 916 52, 993 241, 027 2, 518, 200 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 152, 293 7, 942 5, 830 166, 065 8.00 00900 HOUSEKEEPI NG 454, 230 28, 982 1,736 117, 199 602, 147 9.00 9.00 01000 DI ETARY 214, 120 55, 418 33, 883 305, 607 10 00 10.00 2.186 11.00 01100 CAFETERI A 417, 442 21, 296 6,081 94, 218 539, 037 11.00 01300 NURSING ADMINISTRATION 821, 999 5, 650 232, 819 1, 097, 930 13.00 37, 462 13.00 01400 CENTRAL SERVICES & SUPPLY 261, 396 15, 778 34, 493 49, 650 361, 317 14.00 14.00 524, 409 10, 384 141, 971 15.00 01500 PHARMACY 12.362 689, 126 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 512, 773 35, 593 1, 252 148, 420 698, 038 16.00 01700 SOCIAL SERVICE 17.00 68, 247 2,636 19, 893 90, 776 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 19.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 746, 473 128, 826 41, 252 734, 598 3, 651, 149 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 1,058,672 79,085 174.030 178, 648 1, 490, 435 50.00 53.00 05300 ANESTHESI OLOGY 181, 765 7, 554 39, 817 229, 136 53.00 05400 RADI OLOGY-DI AGNOSTI C 1, 910, 343 59, 552 350, 779 370, 207 2, 690, 881 54.00 54.00 60.00 06000 LABORATORY 1, 994, 625 57, 889 2, 344, 991 60.00 30, 313 262, 164 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 65.00 06500 RESPIRATORY THERAPY 575, 232 35, 937 16, 478 162, 145 789, 792 65.00 06600 PHYSI CAL THERAPY 1, 235, 904 347, 600 66.00 31, 054 8, 367 1, 622, 925 66.00 9, 185 67.00 06700 OCCUPATIONAL THERAPY 323, 657 0 92, 732 425, 574 67.00 68.00 06800 SPEECH PATHOLOGY 136, 698 2, 759 0 38, 922 178, 379 68.00 06900 ELECTROCARDI OLOGY 204, 883 11,071 55, 785 277, 039 69.00 5, 300 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 123, 844 0 0 123, 844 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 358.750 358, 750 72 00 C 0 0 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 112, 128 0 1, 112, 128 73.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.00 349, 924 13, 813 0 57, 992 421, 729 76.00 03950 DIABETIC EDUCATION 76.01 76.01 0 0 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 2, 295, 141 73, 091 19, 660 529, 089 2, 916, 981 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 33, 180, 480 1, 406, 655 1, 239, 912 4, 656, 375 33, 157, 342 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 5, 562 0 5 562 190 00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 252 17, 576 0 17, 828 192. 00 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201. 00 1, 429, 793 1, 239, 912 4, 656, 375 202.00 TOTAL (sum lines 118 through 201) 33, 180, 732 33, 180, 732 202. 00

Provider CCN: 14-1339

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2018 Part I
To 09/30/2019 Date/Time Prepared: 2/26/2020 1:37 pm

				'		2/26/2020 1:3	7 pm
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	·	& GENERAL	PLANT	LINEN SERVICE			
		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	7, 455, 366					5.00
7.00	00700 OPERATION OF PLANT	729, 789	3, 247, 989				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	48, 127	35, 784				8. 00
9.00	00900 HOUSEKEEPI NG	174, 506	130, 585				9. 00
10.00	01000 DI ETARY	88, 567	249, 693			647, 243	10.00
11. 00	01100 CAFETERI A	156, 216	95, 953		· ·	0	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	318, 187	168, 792		0,000	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	104, 712	71, 091	777	9, 688	0	14. 00
15. 00	01500 PHARMACY	199, 713	46, 785		8, 027	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	202, 296	160, 372		0,027	0	16. 00
17. 00	01700 SOCIAL SERVICE	26, 307	11, 875		0	0	17. 00
17. 00	01900 NONPHYSI CLAN ANESTHETI STS	20, 307	11, 675		0	0	19. 00
19.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	J O	0	0	U	U	19.00
30. 00	03000 ADULTS & PEDIATRICS	1, 058, 125	580, 445	121, 225	335, 771	647, 243	30. 00
30.00	ANCILLARY SERVICE COST CENTERS	1,056,125	300, 443	121, 223	333, 771	047, 243	30.00
50. 00	05000 OPERATING ROOM	431, 937	356, 329	19, 395	98, 544	0	50. 00
53. 00	05300 ANESTHESI OLOGY	66, 405	34, 036		· ·	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	779, 833	268, 319	•		0	54. 00
60.00	06000 LABORATORY	679, 592	136, 582		· ·	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0/4, 342	130, 362		02, 202	0	64. 00
65. 00	06500 RESPIRATORY THERAPY	228, 886	161, 921		13, 287	0	65. 00
66. 00	06600 PHYSI CAL THERAPY		139, 918		20, 484	0	66. 00
	06700 OCCUPATIONAL THERAPY	470, 333			· ·	0	67. 00
67. 00		123, 334	41, 384		0,0,0	0	
68. 00	06800 SPEECH PATHOLOGY	51, 695	12, 431	0	7, 751	_	68. 00
69. 00	06900 ELECTROCARDI OLOGY	80, 288	49, 883	0	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	35, 891	0	0	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	103, 968	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	322, 301	0	0	0	0	73.00
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	122, 220	62, 234	0	19, 930	0	76. 00
76. 01	03950 DI ABETI C EDUCATI ON	0	0	0	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS	0.45 050			225 242		
91. 00	09100 EMERGENCY	845, 359	329, 323	60, 613	235, 842	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	SPECIAL PURPOSE COST CENTERS	1		1			
	11300 I NTEREST EXPENSE						113. 00
118.00		7, 448, 587	3, 143, 735	249, 976	881, 915	647, 243	118. 00
	NONREI MBURSABLE COST CENTERS			1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 612	25, 061	0	.,		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	5, 167	79, 193	0	22, 975	0	192. 00
200.00	1 1						200. 00
201.00		0	_ 0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	7, 455, 366	3, 247, 989	249, 976	912, 087	647, 243	202. 00

Provider CCN: 14-1339

				То	09/30/2019	Date/Time Pre 2/26/2020 1:3	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	, p
	'		ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11. 00	13. 00	14. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FLXT						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 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	00/ 400					10.00
11.00	01100 CAFETERI A	806, 433	4 (00 000				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	44, 313	1, 629, 222	F7/ 440			13.00
14.00	01400 CENTRAL SERVI CES & SUPPLY	16, 746	12, 081	576, 412	4 0/4 07/		14.00
15. 00	01500 PHARMACY	23, 440	· ·	755	1, 061, 376	1 115 050	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	54, 344	10,000	0	0	1, 115, 050	16.00
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	4, 739 0		0	0	0	17. 00 19. 00
19.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	U U	U	υĮ	U	19.00
30. 00	03000 ADULTS & PEDIATRICS	184, 379	752, 187	40, 496	0	327, 105	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	104, 377	732, 107	40, 470	<u> </u>	327, 103	30.00
50.00	05000 OPERATING ROOM	39, 080	155, 928	118, 582	ol	74, 807	50.00
53. 00	05300 ANESTHESI OLOGY	10, 900	43, 471	2, 492	ő	7 1, 007	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	85, 150		21, 026	ol	82, 923	54. 00
60.00	06000 LABORATORY	65, 244	o	194, 336	ol	100, 213	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	o	0	ol	0	64. 00
65. 00	06500 RESPIRATORY THERAPY	38, 151	o	1, 032	o	23, 289	65. 00
66. 00	06600 PHYSI CAL THERAPY	67, 002	o	1, 748	o	6, 352	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	15, 304	О	421	o	1, 764	67. 00
68.00	06800 SPEECH PATHOLOGY	7, 464	o	346	o	706	68. 00
69.00	06900 ELECTROCARDI OLOGY	11, 552	o	968	o	18, 349	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	o	39, 187	o	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	113, 515	o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	1, 061, 376	0	73. 00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	14, 672	58, 570	55	0	10, 939	76. 00
76. 01	03950 DI ABETI C EDUCATI ON	0	0	0	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	123, 953	494, 573	41, 396	0	455, 194	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
118.00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	806, 433	1, 629, 222	576, 355	1, 061, 376	1, 101, 641	118. 00
	NONREI MBURSABLE COST CENTERS	_	_1		_1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	57	0	13, 409	1
200.00	1 1	_					200. 00
201.00	1 3	007 400	1 (20 222	0 574 413	1 0/1 27/		201. 00
202.00	TOTAL (sum lines 118 through 201)	806, 433	1, 629, 222	576, 412	1, 061, 376	1, 115, 050	J2U2. UU

Health Financial Systems	TAYLORVILLE MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC	N: 14-1339	Peri od:	Worksheet B	
				From 10/01/2018	Part I	
				To 09/30/2019	Date/Time Pre	pared:
					2/26/2020 1:3	/ pm
Cost Center Description	SOCIAL SERVICE		Subtotal	Intern &	Total	
		ANESTHETI STS		Residents Cost		
				& Post		
				Stepdown		
				Adjustments		
	17. 00	19.00	24. 00	25. 00	26.00	
GENERAL SERVICE COST CENTERS	•					
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 O0400 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 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						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
	150 570					
17. 00 01700 SOCIAL SERVICE	152, 579	l				17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0				19. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	152, 579	0	7, 850, 70	4 -370, 279	7, 480, 425	30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0	2, 785, 03	7 521	2, 785, 558	50.00
53. 00 05300 ANESTHESI OLOGY	0	l ol	386, 44	0	386, 440	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	l ol	3, 999, 89	9 0	3, 999, 899	54.00
60. 00 06000 LABORATORY	0	ol	3, 583, 62		3, 583, 624	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 344, 824	344, 824	64. 00
65. 00 06500 RESPIRATORY THERAPY		0	1, 256, 35		1, 256, 358	65. 00
•		1				
66. 00 06600 PHYSI CAL THERAPY	0	0	2, 345, 34		2, 345, 344	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	613, 87		613, 871	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	258, 77		258, 772	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	438, 07	9 0	438, 079	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	198, 92	2 0	198, 922	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	576, 23	3 0	576, 233	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	o	2, 495, 80	5 0	2, 495, 805	73. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	ol	710, 34		710, 349	76. 00
76. 01 03950 DI ABETI C EDUCATION	0		•	0 13, 118	13, 118	76. 01
OUTPATIENT SERVICE COST CENTERS		<u> </u>		0 13, 110	13, 110	70.01
91. 00 09100 EMERGENCY	1 0	0	5, 503, 23	11 015	E E1E 040	91. 00
	0	٩	5, 505, 25	· ·	5, 515, 049	
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART				0		92. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	152, 579	0	33, 002, 67	1 0	33, 002, 670	118. 00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	39, 43	2 0	39, 432	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0		138, 62		138, 629	
200.00 Cross Foot Adjustments		o o		ó	•	200. 00
201.00 Negative Cost Centers	_			0 0		200.00
202.00 TOTAL (sum lines 118 through 201)	152, 579		33, 180, 73		33, 180, 731	
202.00 TOTAL (Suill TITIES TTO LITTUUGIT 201)	102,079	ı Y	JJ, 10U, /J	۷	33, 100, /31	202.00

| Period: | Worksheet B | From 10/01/2018 | Part II | To 09/30/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1339

				То	09/30/2019	Date/Time Pre 2/26/2020 1:3	
			CAPI TAL REI	ATED COSTS		2/20/2020 1.3	/ piii
	Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	2/1	4.00	
	00100 CAP REL COSTS-BLDG & FIXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 658	0	3, 658	3, 658	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	42, 241	244, 350	409, 587	696, 178	585	5. 00
7.00	00700 OPERATION OF PLANT	0	460, 916	52, 993	513, 909	189	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	7, 942	0	7, 942	5	8. 00
9.00	00900 HOUSEKEEPI NG	0	28, 982	1, 736	30, 718	92	9. 00
10.00	01000 DI ETARY	18, 872	55, 418	2, 186	76, 476	27	10.00
	01100 CAFETERI A	53, 711	21, 296	6, 081	81, 088	74	11. 00
4	01300 NURSING ADMINISTRATION	0	37, 462	5, 650	43, 112	183	13. 00
	01400 CENTRAL SERVICES & SUPPLY	1, 876	15, 778		52, 147	39	14. 00
	01500 PHARMACY	0	10, 384	· ·	22, 746	111	15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	35, 593		36, 845	116	16. 00
4	01700 SOCI AL SERVI CE	0	2, 636		2, 636	16	17. 00
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	4 4 4 4 4	100.007	44.050	407 500	F7.	00.00
	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	16, 444	128, 826	41, 252	186, 522	576	30. 00
	05000 OPERATING ROOM	139	79, 085	174, 030	253, 254	140	50.00
	05300 ANESTHESI OLOGY	139	7, 554		47, 371	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	59, 552		410, 331	290	54.00
1	06000 LABORATORY	0	30, 313		88, 202	206	60.00
	06400 INTRAVENOUS THERAPY	0	0		00, 202	0	64. 00
	06500 RESPIRATORY THERAPY	5, 309	35, 937	16, 478	57, 724	127	65. 00
	06600 PHYSI CAL THERAPY	0,007	31, 054		39, 421	273	66. 00
	06700 OCCUPATI ONAL THERAPY	0	9, 185		9, 185	73	67. 00
	06800 SPEECH PATHOLOGY	0	2, 759		2, 759	31	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	11, 071	5, 300	16, 371	44	69. 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
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	13, 813	0	13, 813	46	76. 00
	03950 DIABETIC EDUCATION	0	0	0	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	0	73, 091	19, 660	92, 751	415	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE	400 500	==	4 000 040	0 705 450	0 (50	113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	138, 592	1, 406, 655	1, 239, 912	2, 785, 159	3, 658	118. 00
+	NONREI MBURSABLE COST CENTERS		F F(2)		F F(2)	0	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-,		5, 562		190.00
200.00	19200 PHYSICIANS' PRIVATE OFFICES Cross Foot Adjustments	0	17, 576	0	17, 576 0	0	192. 00 200. 00
200.00	Negative Cost Centers	-	_		0	0	200.00
201.00	TOTAL (sum lines 118 through 201)	138, 592	1, 429, 793	1, 239, 912	2, 808, 297		201.00
202.00	TOTAL (Sum Times 110 till ough 201)	130, 392	1,447,193	1, 237, 712	2, 000, 297	3, 000	1202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1339

Peri od: Worksheet B From 10/01/2018 Part II To 09/30/2019 Date/Time Prepared:

2/26/2020 1:37 pm Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY LINEN SERVICE & GENERAL PLANT 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 696, 763 5 00 7.00 00700 OPERATION OF PLANT 68, 205 582, 303 7.00 00800 LAUNDRY & LINEN SERVICE 4, 498 8.00 6, 415 18,860 8.00 9.00 00900 HOUSEKEEPI NG 16, 309 23, 411 366 70, 896 9.00 01000 DI ETARY 44, 765 129, 803 10.00 10.00 8.277 150 108 11.00 01100 CAFETERI A 14,600 17, 203 418 753 0 11.00 13.00 01300 NURSING ADMINISTRATION 29, 737 30, 261 0 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 9, 786 12, 745 14 00 59 753 14.00 0 15.00 01500 PHARMACY 18,665 8, 388 0 624 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 18, 906 28, 752 0 0 0 16.00 01700 SOCIAL SERVICE 2, 459 17.00 17.00 2, 129 0 0 0 01900 NONPHYSICIAN ANESTHETISTS O 19.00 0 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 98, 883 9, 146 129, 803 30.00 30.00 104, 063 26, 100 ANCILLARY SERVICE COST CENTERS 50.00 40, 368 50.00 05000 OPERATING ROOM 63.883 1, 463 7,660 0 05300 ANESTHESI OLOGY 6, 206 6, 102 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 72,883 48, 105 1, 405 4, 131 0 54.00 06000 LABORATORY 63, 514 60.00 24, 487 29 4,841 0 60.00 64.00 06400 INTRAVENOUS THERAPY 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 21, 392 29, 029 C 1.033 0 65.00 06600 PHYSI CAL THERAPY 43, 957 25, 085 1, 592 66.00 1.251 0 66.00 06700 OCCUPATIONAL THERAPY 7, 419 67.00 11, 527 0 473 0 67.00 68.00 06800 SPEECH PATHOLOGY 4,831 2, 229 0 602 0 68.00 06900 ELECTROCARDI OLOGY 7,504 8, 943 69.00 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3.354 0 ol 0 71.00 C 07200 IMPL. DEV. CHARGED TO PATIENTS 9.717 0 72.00 C 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 30, 122 0 0 73.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.00 11, 423 11, 157 0 1,549 0 76.00 76 01 03950 DIABETIC EDUCATION 0 0 76 01 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 79, 006 59, 041 4, 573 18, 332 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 129, 803 118. 00 118.00 696, 129 563, 612 18, 860 68, 551 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 151 4, 493 559 14, 198 1, 786 192.00 19200 PHYSICIANS' PRIVATE OFFICES 483 0 0 192. 00 200.00 Cross Foot Adjustments 200.00 201 00 Negative Cost Centers 0 0 201 00 202.00 TOTAL (sum lines 118 through 201) 696, 763 582, 303 18, 860 70, 896 129, 803 202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1339

COST CENTER DESCRIPTION					To	09/30/2019	Date/Time Pre 2/26/2020 1:3	
ADMIN STRATION SERVICE CS SUPPLY LIBRARY		Cost Center Description	CAFFTERLA	NURSLNG	CENTRAL	PHARMACY		/ pili
CEMBRAL SERVICE COST CENTERS		oost conter bescriptron				111/11/11/11/101		
CEMBERAL SERVICE COST CENTERS				, , , , , , , , , , , , , , , , , , , ,				
CEMBEAL SERVICE COST CENTERS			11. 00	13. 00		15. 00		
2.00		GENERAL SERVICE COST CENTERS						
4.00	1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
5.00	2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
7.00	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
8. 00	5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
9.00	7.00	00700 OPERATION OF PLANT						7. 00
10. 00 01000 01000 01000 01000 01000 01000 011	8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
11.00	9.00	00900 HOUSEKEEPI NG						9. 00
13. 00	10.00	01000 DI ETARY						10.00
14. 00	11.00	01100 CAFETERI A	114, 136					11. 00
15.00 01500 PHARMACY	13.00	01300 NURSING ADMINISTRATION	6, 272	109, 565				13. 00
16. 00 01500 MEDI CAL RECORDS & LI BRARY 7, 691 0 0 0 92, 310 16. 00 17. 00 01700 SOCI AL SERVI CE 0 0 0 0 0 17. 00 19. 00 01900 NONPHYSI CI AN AMESTHETI STS 0 0 0 0 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 10. 00 19. 00 19. 00 19. 00 19. 00 10. 00 19. 00 19. 00 19. 00 10. 00 19. 00 19. 00 19. 00 10. 00 19. 00 19. 00 19. 00 10. 00 19. 00 19. 00 19. 00 10. 00 19. 00 19. 00 19. 00 10. 00 19. 00 19. 00 19. 00 10. 00 19. 00 19. 00 19. 00 10. 00 19. 00 19. 00 19. 00 10. 00 19. 00 19. 00 10. 00 19. 00 19. 00 10. 00 19. 00 19. 00 11. 00 19. 00 19. 00 11. 00 19. 00 19. 00 11. 00 19. 00 19. 00 11. 00 19. 00 19. 00 11. 00 19. 00 19. 00 11. 00 19. 00 11. 00 19. 00 19. 00 11. 00 19. 00 19. 00 11. 00 19. 00 11. 00 19. 00 19. 00 11. 00 19.	14.00	01400 CENTRAL SERVICES & SUPPLY	2, 370	812	78, 711			14. 00
17.00 01700 SOCI AL SERVICE 01700 0170 0 0 0 0 0 0 0 0 0	15.00	01500 PHARMACY	3, 317	6, 290	103	60, 244		15. 00
19.00	16.00	01600 MEDICAL RECORDS & LIBRARY	7, 691	0	0	0	92, 310	16. 00
NPATE INT ROUTINE SERVICE COST CENTERS 30.00 00 00 00 00 00 00	17.00	01700 SOCIAL SERVICE	671	1, 270	0	0	0	17. 00
30. 00	19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
ANCILLARY SERVICE COST CENTERS Suppose Cost Centers SerVICE COST CENTERS Suppose Cost Centers Subtotal Cost Centers Subtot		INPATIENT ROUTINE SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM 5,531 10,486 16,193 0 6,193 50.00 0 0 0 0 0 0 0 0 0	30.00		26, 096	50, 585	5, 530	0	27, 080	30. 00
53. 00 05300 ANESTHESI OLOGY 1,543 2,923 340 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 12,051 0 2,871 0 6,865 54. 00 60. 00 06000 LABORATORY 9,234 0 26,538 0 8,296 60. 00 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 5,400 0 141 0 1,928 65. 00 66. 00 06600 PHYSI CAL THERAPY 9,483 0 239 0 526 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 2,166 0 57 0 146 67. 00 68. 00 06800 SPEECH PATHOLOGY 1,056 0 47 0 58 68. 00 69. 00 06900 ELECTROCARDI OLOGY 1,056 0 47 0 58 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 15,501 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 5,351 0 0 72. 00 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 2,077 3,939 7 0 906 76. 00 76. 01 03950 IABETI C EDUCATI ON 0 0 0 0 0 0 79. 00 09200 OSESERVATI ON BEDS (NON-DI STI NCT PART 114,136 109,565 78,703 60,244 91,200 118. 00 118. 00 NONEH IMBURSABLE COST CENTERS 0 0 0 0 0 0 190. 00 09000 Cross Foot Adjustments 0 0 0 0 0 0 200. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 201. 00 00 0 0 0 0 0 0 201. 00 00 0 0 0 0 0 0 0 201. 00 00 00 0 0 0 0 0 201. 00 00 00 00 0 0 0 201. 00 00 00 00 0 0 0								
54. 00							6, 193	1
60. 00 06000 LABORATORY 9, 234 0 26, 538 0 8, 296 60. 00 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 65. 00 06500 RSPIRATORY THERAPY 5, 400 0 141 0 1, 928 65. 00 66. 00 06600 PHYSI CAL THERAPY 9, 483 0 239 0 526 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 2, 166 0 57 0 146 67. 00 68. 00 06800 SPECH PATHOLOGY 1, 056 0 47 0 58 68. 00 69. 00 06900 ELECTROCARDI OLOGY 1, 055 0 132 0 1, 519 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 5, 351 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 5, 351 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 2, 077 3, 939 7 0 906 76. 00 76. 01 001PATI ENT SERVI CE COST CENTERS 113. 00 09100 EMERGENCY 17, 543 33, 260 5, 653 0 37, 683 91. 00 792. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 99. 00 792. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 792. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 792. 00 09200 OBSERVATI ONS' PRI VATE OFFI CES 0 0 0 0 792. 00 09200 OBSERVATI ONS' PRI VATE OFFI CES 0 0 0 0 792. 00 09200 OBSERVATI ONS' PRI VATE OFFI CES 0 0 0 0 792. 00 09200 OBSERVATI ONS' PRI VATE OFFI CES 0 0 0 0 792. 00 09200 OBSERVATI ONS' PRI VATE OFFI CES 0 0 0 0 792. 00 09200 OBSERVATI ONS' PRI VATE OFFI CES 0 0 0 0 792. 00 09200 OBSERVATI ONS' PRI VATE OFFI CES 0 0 0 0 792. 00 09200 OBSERVATI ONS' PRI VATE OFFI CES 0 0 0 0 792. 00 09200 OBSERVATI ONS' PRI VATE OFFI CES 0 0 0 0 792. 00 09200 OBSERVATI ONS' PRI VATE OFFI CES 0 0 0 0 792. 00 09200 OBSERVATI ONS' PRI VATE OFFI CES 0 0 0 0 792. 00 09200 09200 09200 09200 09200 09200 09200 09200			· ·			-	-	
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 5, 400 0 141 0 1, 928 65. 00 66. 00 06600 PHYSI CAL THERAPY 9, 483 0 239 0 526 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 2, 166 0 57 0 146 67. 00 68. 00 06800 SPEECH PATHOLOGY 1, 056 0 47 0 58 68. 00 69. 00 06900 ELECTROCARDI OLOGY 1, 635 0 132 0 1,519 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 5, 351 0 0 71. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 5, 351 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 60, 244 0 73. 00 76. 00 03950 DRUGS CHARGED TO PATI ENTS 0 0 0 60, 244 0 73. 00 76. 01 03950 DIABETI C EDUCATI ON 0 0 0 0 0 00 076. 01 03950 DIABETI C EDUCATI ON 0 0 0 0 0 00 0700 EMERGENCY 0700 MERCENCY 0700 0700 0700 0700 00 0700 DIABETI ENT SERVICE COST CENTERS 0 0 0 0 0 0113. 00 1300 INTEREST EXPENSE 113. 00 118. 00 100 SUBTOTALS (SUM OF LINES 1 through 117) 114, 136 109, 565 78, 703 60, 244 91, 200 192. 00 19200 DRISSENATI ON BEDS (NON-DISTINCT PART 92. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 8 0 1, 110 92. 00 200. 00 Cross Foot Adj ustments 0 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 201. 00 00 00 00 00 00 201. 00 00 00 00 00 00 201. 00 00 00 00 00 00 201. 00 00 00 00 00 00 201. 00 00 00 00 00 201. 00 00 00 00 00 00 201. 00 00 00 00 00 201. 00 00 00 00 00 201. 00 00 00 00 00 201. 00 00 00 00 00 201. 00 00 00 00 00 201. 00 00 00 00 00 201. 00 00 00 00 00 201. 00 00 00 00 201. 00 00 00 00 201. 00 00 00 00 201. 00 00				0		٩		1
65. 00 06500 RESPIRATORY THERAPY 5, 400 0 141 0 1,928 65. 00 66. 00 06600 PHYSI CAL THERAPY 9, 483 0 239 0 526 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 2, 166 0 57 0 146 67. 00 68. 00 06800 SPEECH PATHOLOGY 1,056 0 47 0 58 68. 00 69. 00 06900 ELECTROCARDI OLOGY 1,635 0 132 0 1,519 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 5,351 0 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 15,501 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 15,501 0 0 72. 00 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 2,077 3,939 7 0 906 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 2,077 3,939 7 0 906 76. 00 003550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 2,077 3,939 7 0 906 76. 00 0010 DUTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 17,543 33,260 5,653 0 37,683 91. 00 0010 DUTPATI ENT SERVI CE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 114. 100 NONREI MBURSABLE COST CENTERS 1190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0		~		1
66. 00 06600 PHYSI CAL THERAPY 9, 483 0 239 0 526 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 2, 166 0 57 0 146 67. 00 68. 00 06800 SPECH PATHOLOGY 1, 056 0 47 0 58 68. 00 69. 00 06900 ELECTROCARDI OLOGY 1, 635 0 132 0 1, 519 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 5, 351 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 15, 501 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 15, 501 0 0 72. 00 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 2, 077 3, 939 7 0 906 76. 00 76. 01 03950 DI ABETI C EDUCATI ON 0 0 0 0 0 0 0 0 76. 01 0UTPATI ENT SERVI CE COST CENTERS 91. 00 09200 DISSERVATI ON BEDS (NON-DI STI NCT PART SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 114, 136 109, 565 78, 703 60, 244 91, 200 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 8 0 1, 110 192. 00 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			ı	0		۳Į		
67. 00			· ·	0		0		1
68.00 06800 SPEECH PATHOLOGY 1,056 0 47 0 58 68.00 69.00 06900 ELECTROCARDI OLOGY 1,635 0 132 0 1,519 69.00 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 5,351 0 0 71.00 72.00 72.00 MPL. DEV. CHARGED TO PATIENTS 0 0 0 15,501 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0				0		0		1
69. 00				0		0		1
71. 00				0		0		
72. 00			1, 635	0		-		
73. 00			0	0	•	ĭ	_	
76. 00			0	ŭ		ĭ	_	1
76. 01 03950 DI ABETI C EDUCATI ON 0 0 0 0 0 0 76. 01 0UTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 17, 543 33, 260 5, 653 0 37, 683 91. 00 92. 00 9200 OBSERVATI ON BEDS (NON-DI STI NCT PART 92. 00 11300 I NTEREST EXPENSE 113. 00 INTEREST EXPENSE 113. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 114, 136 109, 565 78, 703 60, 244 91, 200 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 8 0 1, 110 192. 00 200. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			2 077	Ŭ			-	
OUTPATIENT SERVICE COST CENTERS 17,543 33,260 5,653 0 37,683 91.00			· ·			- 1		
91. 00	76.01			U	U	<u> </u>		76.01
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART	01 00		17 5/12	33 260	5 653	ام	37 693	01 00
113.00 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 114,136 109,565 78,703 60,244 91,200 118.00			17, 543	33, 200	5, 055	٩	37,003	1
113.00 118.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	72.00					l		72.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 114, 136 109, 565 78, 703 60, 244 91, 200 118.00	113 00							113 00
NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190.00 192.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 8 0 1,110 192.00 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 0 0 0 0 0 0 201.00			114 136	109 565	78 703	60 244	91 200	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 8 0 1,110 192.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0	110.00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	111,130	107, 000	75, 765	55, 244	, 1, 200	1
192.00 PHYSI CI ANS' PRI VATE OFFI CES 0 0 8 0 1, 110 192.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00	190. 00		0	0	0	ol	0	190.00
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0<			l o	o		-		
201.00 Negative Cost Centers 0 0 0 0 201.00			1			آ	,	1
		, ,	0	0	0	o	0	1
	202.00	TOTAL (sum lines 118 through 201)	114, 136	109, 565	78, 711	60, 244	92, 310	202. 00

Health Financial Systems	TAYLORVILLE MEM	ORIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co	CN: 14-1339	Peri od:	Worksheet B	
				From 10/01/2018		
				To 09/30/2019		
					2/26/2020 1:3	7 pm
Cost Center Description	SOCI AL SERVI CE		Subtotal	Intern &	Total	
		ANESTHETI STS		Residents Cost		
				& Post		
				Stepdown		
				Adjustments		
	17. 00	19.00	24.00	25. 00	26.00	
GENERAL SERVICE COST CENTERS	•	'		<u>'</u>		
1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
					ł	
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						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 & LI BRARY						16.00
	0 101					
17. 00 01700 SOCI AL SERVI CE	9, 181					17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0				19. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	9, 181		673, 56	5 0	673, 565	30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0		405, 17	1 0	405, 171	50.00
53. 00 05300 ANESTHESI OLOGY	0		64, 48	5 0	64, 485	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		558, 93			
60. 00 06000 LABORATORY	0		225, 34			60.00
64. 00 06400 I NTRAVENOUS THERAPY	0			0 0		64.00
65. 00 06500 RESPIRATORY THERAPY	0		116, 77	ا ا	1	
66. 00 06600 PHYSI CAL THERAPY						66.00
	1		121, 82		,	
67. 00 06700 OCCUPATI ONAL THERAPY	0		31, 04			1
68. 00 06800 SPEECH PATHOLOGY	0		11, 61		11, 613	
69. 00 06900 ELECTROCARDI OLOGY	0		36, 14			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		8, 70	5 0	8, 705	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		25, 21	8 0	25, 218	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		90, 36	6 0	90, 366	73. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		44, 91	7 0	44, 917	76.00
76. 01 03950 DIABETIC EDUCATION	0			o	1	76. 01
OUTPATIENT SERVICE COST CENTERS		1		<u> </u>		70.0.
91. 00 09100 EMERGENCY	1 0		348, 25	7 0	348, 257	91.00
			340, 23	/		92.00
				1 0		92.00
SPECIAL PURPOSE COST CENTERS	_					
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	9, 181	0	2, 762, 37	1 0	2, 762, 371]118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		10, 76	5 0	10, 765	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0		35, 16	1 0	35, 161	192. 00
200.00 Cross Foot Adjustments		0	1	0		200.00
201.00 Negative Cost Centers	0	Ō		o o		201. 00
202.00 TOTAL (sum lines 118 through 201)	9, 181				l e	
	7, 101	,	2,000,27	., 0	2,000,277	1=02.00

		ATLORVILLE IVILIVI		011 44 4000 5		u or rorm cm3-2		
COST	LLOCATION - STATISTICAL BASIS		Provi der C	UN: 14-1339 P	'eri od:	Worksheet B-1		
						From 10/01/2018 To 09/30/2019 Date/Time Prepare		
				1	0 09/30/2019	2/26/2020 1:3	pareu:	
		CADITAL DEL	LATED COSTS			2/20/2020 1.3	7 pili	
		CAPITAL REI	LATED COSTS					
			I					
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE		
		(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS		& GENERAL		
				DEPARTMENT		(ACCUM. COST)		
				(GROSS		, , , ,		
				SALARI ES)				
		1.00	2.00		ГА	F 00		
	DENIEDAL DEDILLOS DOOT DENIEDO	1.00	2.00	4. 00	5A	5. 00		
	GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT	162, 207					1.00	
2.00	00200 CAP REL COSTS-MVBLE EQUIP		1, 230, 016				2. 00	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	415		1			4.00	
5. 00	00500 ADMINISTRATIVE & GENERAL	27, 721				25, 725, 366		
	1	1					1	
7. 00	00700 OPERATION OF PLANT	52, 290				_, _, _,,		
8.00	00800 LAUNDRY & LINEN SERVICE	901	0	18, 672	. 0	166, 065	8. 00	
9.00	00900 HOUSEKEEPI NG	3, 288	1, 722	375, 331	0	602, 147	9. 00	
10.00	01000 DI ETARY	6, 287				305, 607		
11. 00	01100 CAFETERI A	2, 416				539, 037		
13. 00	01300 NURSING ADMINISTRATION	4, 250				1, 097, 930		
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 790	34, 218	159, 004	0	361, 317	14. 00	
15.00	01500 PHARMACY	1, 178	12, 263	454, 665	0	689, 126	15. 00	
16.00	01600 MEDICAL RECORDS & LIBRARY	4, 038	1, 242	475, 318	0	698, 038	16. 00	
17. 00	01700 SOCIAL SERVICE	299				90, 776	1	
						1		
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	C	0	0	19. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	14, 615	40, 923	2, 352, 557	0	3, 651, 149	30.00	
	ANCILLARY SERVICE COST CENTERS	•						
50.00	05000 OPERATI NG ROOM	8, 972	172, 641	572, 123	0	1, 490, 435	50.00	
	1						1	
53. 00	05300 ANESTHESI OLOGY	857						
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 756	347, 980	1, 185, 592	. 0	2, 690, 881	54. 00	
60.00	06000 LABORATORY	3, 439	57, 427	839, 582	. 0	2, 344, 991	60.00	
64.00	06400 I NTRAVENOUS THERAPY	0				0	64. 00	
65. 00	06500 RESPI RATORY THERAPY	4, 077				789, 792	1	
		The state of the s				l	1	
66. 00	06600 PHYSI CAL THERAPY	3, 523				1, 622, 925		
67.00	06700 OCCUPATI ONAL THERAPY	1, 042	0	296, 976	0	425, 574	67. 00	
68.00	06800 SPEECH PATHOLOGY	313	0	124, 647	0	178, 379	68. 00	
69.00	06900 ELECTROCARDI OLOGY	1, 256	5, 258	178, 651	0	277, 039		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,200	0,230			123, 844		
						1		
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1	0	358, 750		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	1, 112, 128	73. 00	
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 567	0	185, 719	0	421, 729	76. 00	
76. 01	03950 DIABETIC EDUCATION	0	0		Ō	0	76. 01	
	OUTPATIENT SERVICE COST CENTERS		-		-		1	
01 00	09100 EMERGENCY	8, 292	19, 503	1, 694, 414	. 0	2, 916, 981	91.00	
		8, 292	19, 503	1, 094, 414	. 0	2, 910, 981		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					<u> </u>	92. 00	
	SPECIAL PURPOSE COST CENTERS							
113.00	11300 NTEREST EXPENSE					<u> </u>	113. 00	
118.00		159, 582	1, 230, 016	14, 912, 083	-7, 455, 366	25, 701, 976	1	
	NONREI MBURSABLE COST CENTERS	137,302	1, 230, 010	11, 712, 000	,, 400, 000	20, 701, 770	1	
100 00		/ / / /	1 ^	1 -		F F (2	100 00	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	631		•			190. 00	
192.00	19200 PHYSICIANS' PRIVATE OFFICES	1, 994	0	C	0	17, 828	192. 00	
200.00	Cross Foot Adjustments						200. 00	
201.00							201. 00	
202.00	9	1, 429, 793	1, 239, 912	1 454 275		7, 455, 366		
202.00		1,429,193	1, 239, 912	4, 656, 375	1	7, 455, 500	202.00	
	Part I)							
203.00	Unit cost multiplier (Wkst. B, Part I)	8. 814620	1. 008045	0. 312255		0. 289806	203. 00	
204.00	Cost to be allocated (per Wkst. B,			3, 658		696, 763	204. 00	
	Part II)							
205.00				0. 000245		0. 027085	205 00	
200.00	· · · · · · · · · · · · · · · · · · ·			0.000243]	0.027000	200.00	
201 00	NAUE adjustment analyst to be allegated	-				i	20/ 22	
206.00						i	206. 00	
	(per Wkst. B-2)							
207.00	NAHE unit cost multiplier (Wkst. D,			1		i	207. 00	
	Parts III and IV)					i		
	· · · ·	•		•			•	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS TAYLORVILLE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Peri od: From 10/01/2018 To 09/30/2019 Date/Ti me Prepared: 2/26/2020 1:37 pm Provider CCN: 14-1339

	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	, p
		PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(HOURS OF SERVICE)	(MEALS SERVED)	(MEALS SERVED)	
		(SQUARE TEET)	LAUNDRY)	JERVI CE)			
		7. 00	8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT	81, 781	040 757				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	901	212, 757				8. 00
9.00	00900 HOUSEKEEPI NG	3, 288			00.000		9.00
10.00	01000 DI ETARY	6, 287			22, 239	40.000	10.00
11.00	01100 CAFETERI A	2, 416		35 0	0	40, 838	1
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	4, 250		35	0	2, 244	1
15. 00	01500 PHARMACY	1, 790 1, 178		29	0	848 1, 187	15. 00
	01600 MEDICAL RECORDS & LIBRARY	4, 038		0	0	2, 752	1
	01700 SOCIAL SERVICE	299		·	0	2, 732	1
	01900 NONPHYSICIAN ANESTHETISTS	277		1	0	0	1
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		0	0	0	0	17.00
30. 00	03000 ADULTS & PEDI ATRI CS	14, 615	103, 177	1, 213	22, 239	9, 337	30.00
00.00	ANCI LLARY SERVI CE COST CENTERS	1.7010	100/177	1,72.0	22,207	7,007	00.00
50.00	05000 OPERATI NG ROOM	8, 972	16, 507	356	0	1, 979	50.00
53. 00	05300 ANESTHESI OLOGY	857		0	0	552	•
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 756	15, 848	192	0	4, 312	54.00
60.00	06000 LABORATORY	3, 439		225	0	3, 304	•
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	4, 077	0	48	0	1, 932	65. 00
66.00	06600 PHYSI CAL THERAPY	3, 523	14, 113	74	0	3, 393	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 042	0	22	0	775	67. 00
68. 00	06800 SPEECH PATHOLOGY	313	0	28	0	378	68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 256	0	0	0	585	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 567		. –	0	743	1
76. 01	03950 DI ABETI C EDUCATION	0	0	0	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	8, 292	51, 588	852	0	6, 277	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		T	T			113. 00
118.00		79, 156	212, 757	3, 186	22, 239	40, 838	1
110.00	NONREI MBURSABLE COST CENTERS	77, 130	212, 737	3, 100	22, 237	40, 636	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	631	О	26	0	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 994			0		192. 00
200.00		1, 7,7		03	O		200.00
201.00	1 1						201. 00
202. 00		3, 247, 989	249, 976	912, 087	647, 243	806, 433	l
	Part I)			,	2, =		
203.00		39. 715692	1. 174937	276. 809408	29. 103962	19. 747123	203. 00
204.00		582, 303			129, 803	114, 136	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	7. 120272	0. 088646	21. 516237	5. 836728	2. 794848	205. 00
	[11]						
206. 00							206. 00
007.00	(per Wkst. B-2)						007.00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
	raitSiii alluiv)	I	I	I		I	I

Health Financial Systems	TAYLORVILLE MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 14 1220	Pori od:	Workshoot P 1

Health Financial Systems	TAYLORVILLE MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		eri od:	Worksheet B-1	
				rom 10/01/2018	5	
			T	o 09/30/2019	Date/Time Pre 2/26/2020 1:3	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
cost center bescriptron	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	SOCIAL SERVICE	
	ADIVITIVI STRATTON	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
	(DI DECT NDSI NC		REQUIS.)		(ITWE SPENT)	
	(DI RECT NRSI NG	(COSTED		(TIME SPENT)		
	HRS)	REQUIS.)	15.00	1/ 00	17.00	
OFNEDAL CEDIU OF COCT OFNEDO	13. 00	14. 00	15. 00	16. 00	17. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 O0700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEP I NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11. 00
13.00 O1300 NURSING ADMINISTRATION	183, 006					13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	1, 357	1, 821, 672	2			14.00
15. 00 01500 PHARMACY	10, 506	2, 387	1, 112, 128			15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	o	. 0	0	3, 160		16.00
17. 00 01700 SOCIAL SERVICE	2, 121	0	0	l ol	2, 121	17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS	o	0	0	0	. 0	1
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>		,	<u>ا</u>		17.00
30. 00 03000 ADULTS & PEDIATRICS	84, 491	127, 981	0	927	2, 121	30.00
ANCI LLARY SERVI CE COST CENTERS	04, 471	127, 701		721	2, 121	30.00
50. 00 05000 OPERATING ROOM	17, 515	374, 763	0	212	0	50.00
53. 00 05300 ANESTHESI OLOGY	4, 883	7, 876	•		0	
1	1		1		0	1
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	66, 449				
60. 00 06000 LABORATORY	0	614, 179	1		0	1
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	
65. 00 06500 RESPI RATORY THERAPY	0	3, 262		66	0	
66. 00 06600 PHYSI CAL THERAPY	0	5, 524		18	0	1
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 329		5	0	
68. 00 06800 SPEECH PATHOLOGY	0	1, 092	1		0	1
69. 00 06900 ELECTROCARDI OLOGY	0	3, 058	1	52	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	123, 844	0	0	0	
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS	0	358, 750	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	1, 112, 128	0	0	73. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	6, 579	173	0	31	0	76. 00
76. 01 03950 DI ABETI C EDUCATI ON	0	0	0	0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	55, 554	130, 826	0	1, 290	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS	·		•			1
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	183, 006	1, 821, 493	1, 112, 128	3, 122	2, 121	118. 00
NONREI MBURSABLE COST CENTERS	,	.,,,	1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1	J,		1
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	O	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	o	179				192. 00
200.00 Cross Foot Adjustments	١	177		30	O	200.00
201.00 Negative Cost Centers						201.00
	1 420 222	E74 /11	1 041 274	1 115 050	152 570	
202.00 Cost to be allocated (per Wkst. B, Part I)	1, 629, 222	576, 412	1, 061, 376	1, 115, 050	152, 579	202.00
	0.000571	0 21/410	0.054345	252 042024	71 027204	202 00
203.00 Unit cost multiplier (Wkst. B, Part I)	1	0. 316419			71. 937294	
204.00 Cost to be allocated (per Wkst. B,	109, 565	78, 711	60, 244	92, 310	9, 181	204. 00
Part II)	0.500/0/	0.040000	0.054470	00 040005	4 000/40	005 00
205.00 Unit cost multiplier (Wkst. B, Part	0. 598696	0. 043208	0. 054170	29. 212025	4. 328619	205.00
NAME adjustment amount to be all control						20/ 22
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)			I	l l		I

From 10/01/2018 To 09/30/2019 Date/Time Prepared: 2/26/2020 1:37 pm Cost Center Description NONPHYSI CI AN ANESTHETI STS (ASSI GNED TIME) 19.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11. 00 01100 CAFETERIA 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 0 30.00 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 53. 00 | 05300 | ANESTHESI OLOGY 000000000000 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54 00 60.00 06000 LABORATORY 60.00 64. 00 06400 I NTRAVENOUS THERAPY 64.00 65. 00 06500 RESPIRATORY THERAPY 65 00 06600 PHYSI CAL THERAPY 66.00 66.00 67. 00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 69. 00 06900 ELECTROCARDI OLOGY 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.00 76.00 03950 DIABETIC EDUCATION 76.01 76.01 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 0 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 203 00 204.00 Cost to be allocated (per Wkst. B, 204.00 Part II) Unit cost multiplier (Wkst. B, Part 0.000000 205.00 205.00 11) NAHE adjustment amount to be allocated 206.00 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

TAYLORVILLE MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10
Worksheet B-2

Health Financial Systems
POST STEPDOWN ADJUSTMENTS

Health Financial Systems T	AYLORVILLE MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10			
POST STEPDOWN ADJUSTMENTS	Provider CCN: 14-1339		Peri od: Worksheet B-2			
			From 10/01/2018 To 09/30/2019	Date/Time Pre 2/26/2020 1:3		
		Wor	ksheet			
	Description	CODE	Li ne No.	Amount		
	1. 00	2. 00	3. 00	4. 00		
	ADJ FOR EPO COSTS IN RENAL DIALYSIS		1 74.00	0	1. 00	
	ADJ FOR EPO COSTS IN HOME PROGRAM		1 94.00	0	2. 00	
	ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1 74.00	0	3. 00	
	ADJ FOR ARANESP COSTS IN HOME PROGRAM		1 94.00	0	4. 00	
	ADJ FOR ESA COSTS IN RENAL DIALYSIS		1 74.00	0	5. 00	
	ADJ FOR ESA COSTS IN HOME PROGRAM		1 94.00	0	6. 00	
7. 00	IV THERAPY & ANCILLARIES		1 30.00	-357, 161	7. 00	
8. 00	ANCI LLARI ES		1 50.00	521	8. 00	
9. 00	IV THERAPY		1 64.00	344, 824	9. 00	
10. 00	ANCI LLARI ES		1 91.00	11, 815	10.00	
11. 00	DIABETIC EDUCATION		1 30.00	-13, 118	11.00	
12. 00	DIABETIC EDUCATION		76. 01	13, 118	12. 00	

ealth Financial Systems	TAYLORVILLE MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC		Peri od: From 10/01/2018 To 09/30/2019	Worksheet C Part I Date/Time Pre 2/26/2020 1:3	
		Title	XVIII	Hospi tal	Cost	
		·		Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2, 00	3, 00	4. 00	5. 00	

				·	Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	7, 480, 425		7, 480, 425	0	0	30. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	2, 785, 558		2, 785, 558		0	
53.00	05300 ANESTHESI OLOGY	386, 440	l e	386, 440		0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 999, 899	l e	3, 999, 899		0	54.00
60. 00	06000 LABORATORY	3, 583, 624		3, 583, 624	0	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	344, 824		344, 824	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	1, 256, 358	0	1, 256, 358	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 345, 344	0	2, 345, 344	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	613, 871	0	613, 871	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	258, 772	0	258, 772	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	438, 079		438, 079	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	198, 922		198, 922	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	576, 233		576, 233	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 495, 805		2, 495, 805	0	0	73. 00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	710, 349		710, 349	0	0	76. 00
76. 01	03950 DIABETIC EDUCATION	13, 118		13, 118	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	5, 515, 049		5, 515, 049	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	372, 211		372, 211		0	92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	33, 374, 881	0	33, 374, 881	0	0	200. 00
201.00	Less Observation Beds	372, 211		372, 211		0	201. 00
202.00	Total (see instructions)	33, 002, 670	0	33, 002, 670	0	0	202. 00

Health Financial Systems	TAYLORVILLE MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Peri od: From 10/01/2018 To 09/30/2019	Worksheet C Part I Date/Time Pre 2/26/2020 1:3	pared: 7 pm
		Ti tl e	e XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
·	·	·	+ col. 7)	Ratio	Inpati ent	
			,		Rati o	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	·					
30, 00 03000 ADULTS & PEDI ATRI CS	5, 833, 546		5, 833, 54	6		30.00

		Charges		·		
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Rati o	
	6. 00	7. 00	8. 00	9. 00	10. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				1		
30. 00 03000 ADULTS & PEDI ATRI CS	5, 833, 546		5, 833, 546			30. 00
ANCILLARY SERVICE COST CENTERS				I		
50. 00 05000 OPERATI NG ROOM	365, 587	3, 573, 115			0. 000000	
53. 00 05300 ANESTHESI OLOGY	135, 747	627, 593	·		0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 019, 856	35, 582, 387			0. 000000	
60. 00 06000 LABORATORY	2, 250, 071	11, 705, 294			0. 000000	
64. 00 06400 I NTRAVENOUS THERAPY	16, 522	2, 036, 389			0. 000000	
65. 00 06500 RESPIRATORY THERAPY	1, 365, 465	2, 411, 663			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	769, 695	3, 956, 740			0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	844, 639	560, 801	1, 405, 440		0.000000	
68. 00 06800 SPEECH PATHOLOGY	259, 846	676, 041	·		0.000000	
69. 00 06900 ELECTROCARDI OLOGY	160, 671	2, 171, 772	2, 332, 443		0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	506, 626	516, 654			0.000000	
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	919, 487	1, 406, 635			0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 861, 758	6, 356, 518			0.000000	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	638, 930	638, 930	1. 111779	0.000000	76. 00
76. 01 03950 DI ABETI C EDUCATION	19, 561	14, 637	34, 198	0. 383590	0.000000	76. 01
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	182, 406	14, 871, 463	15, 053, 869		0.000000	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 013, 122	1, 013, 122	0. 367390	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS					
113.00 11300 I NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	17, 511, 483	88, 119, 754	105, 631, 237			200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	17, 511, 483	88, 119, 754	105, 631, 237			202. 00

From 10/01/2018 Part I To 09/30/2019 Date/Time Pre	-2552-10	u of Form CMS-2			AYLORVILLE MEMORI	<u> </u>	
INPATIENT ROUTINE SERVICE COST CENTERS 11.00		Worksheet C Part I Date/Time Pre 2/26/2020 1:3		Provider CCN: 14-1339		ATION OF RATIO OF COSTS TO CHARGES	COMPUTA
Ratio 11.00		Cost	Hospi tal	Title XVIII			
30. 00 03000 ADULTS & PEDI ATRI CS ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 0. 000000 53. 00 05300 ANESTHESI OLOGY 0. 000000 60. 00 06400 RADI OLOGY-DI AGNOSTI C 0. 000000 64. 00 06400 INTRAVENOUS THERAPY 0. 000000 65. 00 06500 RESPI RATORY THERAPY 0. 000000 66. 00 06600 PHYSI CAL THERAPY 0. 000000 67. 00 06600 PHYSI CAL THERAPY 0. 000000 68. 00 06600 SPEECH PATHOLOGY 0. 000000 69. 00 06900 ELECTROCARDI OLOGY 0. 000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 000000 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 74. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 75. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000 76. 01 07100 EMERGENCY 0. 000000 77. 00 07100 EMERGENCY 0. 000000					Rati o	Cost Center Description	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 0.000000 53. 00 05300 ANESTHESI OLOGY 0.000000 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 60. 00 06000 LABORATORY 0.000000 64. 00 06400 INTRAVENOUS THERAPY 0.000000 65. 00 06500 RESPI RATORY THERAPY 0.000000 66. 00 06600 PHYSI CAL THERAPY 0.000000 67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 68. 00 06800 SPEECH PATHOLOGY 0.000000 69. 00 06900 ELECTROCARDI OLOGY 0.000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 76. 01 03950 DI ABETI C EDUCATI ON 0.000000 0UTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 0.000000						INPATIENT ROUTINE SERVICE COST CENTERS	I
50. 00	30.00					03000 ADULTS & PEDIATRICS	30.00
53. 00						ANCILLARY SERVICE COST CENTERS	F
54. 00	50. 00				0. 000000	05000 OPERATING ROOM	50.00
60. 00	53. 00				0. 000000	05300 ANESTHESI OLOGY	53.00
64. 00	54. 00						
65. 00	60.00				0. 000000	06000 LABORATORY	60.00
66. 00	64. 00						
67. 00	65. 00						
68. 00	66. 00						
69. 00	67. 00						
71. 00	68. 00						
72. 00	69. 00						
73. 00	71. 00						
76. 00 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	72. 00						
76. 01 03950 DI ABETI C EDUCATI ON 0. 000000 OUTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 0. 000000	73. 00						
0UTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 0. 000000	76. 00						
91. 00 09100 EMERGENCY 0. 000000	76. 01				0. 000000		
92 ON INGONIORSERVATION BEDS (NON-DISTINCT PART 0 0000000)	91.00						
	92. 00				0. 000000		
SPECIAL PURPOSE COST CENTERS	440.00						
113.00 INTEREST EXPENSE 200.00 Subtotal (see instructions)	113.00						

113. 00 200. 00 201. 00 202. 00

200.00

201. 00 202. 00 Subtotal (see instructions)

Less Observation Beds Total (see instructions)

Health Financial Systems	TAYLORVILLE MEM	ORIAI HOSPITAI		In lie	eu of Form CMS-:	2552_10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der Co	CN: 14-1339	Peri od:	Worksheet D	2332-10
				From 10/01/2018 To 09/30/2019		pared: 7 pm
		Title	: XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	_					
50.00 05000 OPERATING ROOM	405, 171		•			
53. 00 05300 ANESTHESI OLOGY	64, 485		l .			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	558, 932		l .			
60. 00 06000 LABORATORY	225, 347	13, 955, 365			18, 328	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	_, _,				
65. 00 06500 RESPI RATORY THERAPY	116, 774	3, 777, 128	0. 03091	6 638, 893	19, 752	65. 00
66. 00 06600 PHYSI CAL THERAPY	121, 827	4, 726, 435	0. 02577	'6 101, 566	2, 618	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	31, 046	1, 405, 440			2, 369	67. 00
68. 00 06800 SPEECH PATHOLOGY	11, 613	935, 887	0. 01240	55, 901	694	68. 00
69. 00 06900 ELECTROCARDI OLOGY	36, 148				1, 159	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8, 705		0. 00850	237, 466	2, 020	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	25, 218	2, 326, 122	0. 01084	536, 611	5, 817	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	90, 366	8, 218, 276	0. 01099	722, 809	7, 948	73. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	44, 917	638, 930	0. 07030	0 0	0	76. 00
76.01 03950 DIABETIC EDUCATION	0	34, 198	0.00000	3, 519	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	348, 257	15, 053, 869			0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	33, 515	1, 013, 122	0. 03308	31 0	0	92.00
200.00 Total (lines 50 through 199)	2, 122, 321	99, 797, 691		5, 076, 823	107, 771	200. 00

Health Financial Systems	TAYLORVILLE MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-1339	Peri od: From 10/01/2018 To 09/30/2019	Worksheet D Part IV Date/Time Prepared:

						2/26/2020 1:3	7 pm
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	C	0	0	50.00
53.00	05300 ANESTHESI OLOGY	0	0	C	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54. 00
60.00	06000 LABORATORY	0	0	C	0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	C	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0	C	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	C	0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	C	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	C	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	C	0	0	76. 00
76. 01	03950 DIABETIC EDUCATION	0	0	C	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0	C	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		[c		0	92.00
200.00	Total (lines 50 through 199)	0	0	C	0	0	200. 00

Health Financial Systems	TAYLORVILLE MEMORIA	AL HOSPITAL	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT AND THROUGH COSTS	ICILLARY SERVICE OTHER PASS		Peri od: From 10/01/2018 To 09/30/2019	Worksheet D Part IV Date/Time Prepared: 2/26/2020 1:37 pm	
		Title XVIII	Hospi tal	Cost	
Cost Center Description		Total Cost Total		Ratio of Cost	

					2/26/2020 1:3	/ pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS			,	_		
50. 00 05000 OPERATING ROOM	0	0	(3, 938, 702		1
53. 00 05300 ANESTHESI OLOGY	0	0	(763, 340		1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(37, 602, 243		
60. 00 06000 LABORATORY	0	0	(13, 955, 365		
64. 00 06400 I NTRAVENOUS THERAPY	0	0	(2, 052, 911		1
65. 00 06500 RESPI RATORY THERAPY	0	0	(3, 777, 128		1
66. 00 06600 PHYSI CAL THERAPY	0	0	(4, 726, 435		1
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(1, 405, 440	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	(935, 887	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(2, 332, 443	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(1, 023, 280	0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(2, 326, 122	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(8, 218, 276	0.000000	73. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	C	638, 930	0.000000	76. 00
76.01 03950 DIABETIC EDUCATION	0	0	C	34, 198	0.000000	76. 01
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0	C	15, 053, 869	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(1, 013, 122	0.000000	92. 00
200.00 Total (lines 50 through 199)	0	0	(99, 797, 691		200. 00
					·	

	TAYLORVILLE MEMOR		N 14 1220		eu of Form CMS-2	<u>2552-10</u>
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE UTHER PASS	Provider CO		Peri od: From 10/01/2018	Worksheet D Part IV	
THROUGH COSTS				To 09/30/2019		pared:
					2/26/2020 1:3	7 pm
			XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCI LLARY SERVI CE COST CENTERS	T		T	T		
50. 00 05000 OPERATI NG ROOM	0. 000000	221, 511		0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000	84, 045		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 155, 729		0	0	
60. 00 06000 LABORATORY	0. 000000	1, 135, 003		0	0	00.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	1, 756		0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 000000	638, 893		0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 000000	101, 566		0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	107, 226		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	55, 901		0	0	00.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	74, 788		0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	237, 466		0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	536, 611		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	722, 809		0	0	73. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0.000000	0		0	0	76. 00
76. 01 03950 DIABETIC EDUCATION	0. 000000	3, 519		0 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0. 000000	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		5, 076, 823		0 0	0	200. 00

Health Financial Systems	TAYLORVILLE MEMORI	AL HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1339	Peri od:	Worksheet D
			From 10/01/2018	

	·				From 10/01/2018 To 09/30/2019		pared:
			Title	XVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCI LLARY SERVI CE COST CENTERS	T					
50.00	05000 OPERATING ROOM	0. 707227	0	1, 643, 40		0	
53. 00	05300 ANESTHESI OLOGY	0. 506249		218, 852		0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 106374		13, 976, 216		0	54. 00
60.00	06000 LABORATORY	0. 256792		4, 573, 119		0	60. 00
64. 00	06400 I NTRAVENOUS THERAPY	0. 167968	l .	1, 017, 909		0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 332623		1, 041, 16		0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 496218		1, 426, 596		0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 436782		196, 982	2 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 276499	0	40, 36	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 187820	0	1, 004, 266	6 0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 194396	0	192, 328	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 247723	0	741, 896	6 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 303690	0	3, 908, 756	6, 438	0	73. 00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1. 111779	0	548, 87	7 0	0	76. 00
76. 01	03950 DIABETIC EDUCATION	0. 383590	0	14, 63	7 0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	0. 366354	0	4, 427, 590	1, 534	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 367390	0	593, 493	0	0	92.00
200.00	Subtotal (see instructions)		0	35, 566, 450	7, 972	0	200. 00
201.00				(0		201. 00
	Only Charges			05 5// 45/			
202.00	Net Charges (line 200 - line 201)		0	35, 566, 450	7, 972	1 0	202. 00

Health Financial	Systems			TAYLORVI L	LE MEMORI.	AL HOSPITAL			In Lieu	ı of Form CM	S-2552-10
APPORTI ONMENT OF	MEDI CAL,	OTHER HEALTH	SERVI CES	AND VACCINE	COST	Provi der CC	N: 14-1339	From	10/01/2018 09/30/2019		repared:

			-	Го 09/30/2019	Date/Time Pre 2/26/2020 1:3	
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANCILL ADV. CEDVI CE. COCT. CENTEDO	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS 50. 00 O5000 OPERATING ROOM	1 1/2 2/2		I			
	1, 162, 262	l				50.00
53. 00 05300 ANESTHESI OLOGY	110, 794	l .				53. 00 54. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 60. 00 06000 LABORATORY	1, 486, 706					60.00
60. 00 06000 LABORATORY 64. 00 06400 NTRAVENOUS THERAPY	1, 174, 340	l .				64.00
	170, 976	l .				
65. 00 06500 RESPIRATORY THERAPY	346, 315	l .				65.00
66. 00 06600 PHYSI CAL THERAPY	707, 903					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	86, 038	l .				67.00
68. 00 06800 SPEECH PATHOLOGY	11, 160	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	188, 621	0				69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	37, 388					71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	183, 785					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 187, 050					73.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 01 03950 DI ABETI C EDUCATI ON	610, 230 5, 615	l e				76. 00 76. 01
OUTPATIENT SERVICE COST CENTERS	5,615	0				76.01
91. 00 O9100 EMERGENCY	1, 622, 065	562				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	218, 043					92.00
200.00 Subtotal (see instructions)	9, 309, 291	2, 517				200.00
201.00 Less PBP Clinic Lab. Services-Program	7, 309, 291	2,317				200.00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)	9, 309, 291	2, 517				202. 00

Heal th	Financial Systems	TAYLORVILLE MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ID VACCINE COST	Provi der C		Period: From 10/01/2018		
					To 09/30/2019	2/26/2020 1:3	pared: 7 pm
			Title		Swing Beds - SNF		
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.			
		4.00	0.00	(see inst.)	(see inst.)	F 00	
	ANCILLARY CERVICE COCT CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
F0 00	ANCI LLARY SERVI CE COST CENTERS	0.707027					FO 00
	05000 OPERATING ROOM	0. 707227	0			0	00.00
	05300 ANESTHESI OLOGY	0. 506249	0			0	53.00
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0. 106374	0			0	54.00
	06400 I NTRAVENOUS THERAPY	0. 256792 0. 167968	0			0	60. 00 64. 00
	1 1		0			0	
	06500 RESPI RATORY THERAPY	0. 332623	0			0	65. 00
	06600 PHYSI CAL THERAPY	0. 496218	0			0	66. 00 67. 00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0. 436782 0. 276499	0			0	68.00
	06900 ELECTROCARDI OLOGY		0			0	
		0. 187820	0			Ŭ	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 194396	0			0	
	07200 DRUCS CHARGED TO PATIENTS	0. 247723	0			0	, 00
	07300 DRUGS CHARGED TO PATIENTS	0. 303690	0			0	73.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1. 111779	0		U U	0	76.00

0. 383590

0. 366354 0. 367390

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91. 00 92. 00

201. 00

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76.01

91.00

92.00

200.00

201.00

202.00

09200 OBSERVATION BEDS (NON-DISTINCT PART

Less PBP Clinic Lab. Services-Program

Only Charges Net Charges (line 200 - line 201)

Subtotal (see instructions)

OUTPATIENT SERVICE COST CENTERS

03950 DIABETIC EDUCATION

09100 EMERGENCY

Health Financial Systems	TAYLORVILLE ME	MORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH	SERVICES AND VACCINE COST	Provi der (CCN: 14-1339	Peri od: From 10/01/2018	Worksheet D	
		Component	CCN: 14-Z339	To 09/30/2019	Part V Date/Time Pre	nared.
		Component	0011. 11 2007	10 077 007 2017	2/26/2020 1:3	
			e XVIII	Swing Beds - SNF	Cost	
		osts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins (see inst.)					
	6. 00	(see inst.) 7.00	\dashv			
ANCILLARY SERVICE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM		0				50.00
3. 00 05300 ANESTHESI OLOGY		o	ol			53.00
64. 00 05400 RADI OLOGY-DI AGNOSTI C		0				54.00
00. 00 06000 LABORATORY		0	o			60.00
4.00 06400 INTRAVENOUS THERAPY		0	0			64.00
5. 00 06500 RESPIRATORY THERAPY		0	0			65.00
6. 00 06600 PHYSI CAL THERAPY		0	0			66. 00
7. 00 06700 OCCUPATI ONAL THERAPY		0	0			67.00
8.00 06800 SPEECH PATHOLOGY		0	0			68.00
9. 00 06900 ELECTROCARDI OLOGY		0	0			69.00
1.00 07100 MEDICAL SUPPLIES CHARGED T		0	0			71.00
2.00 07200 IMPL. DEV. CHARGED TO PATI	ENTS	0	0			72. 00
3.00 07300 DRUGS CHARGED TO PATIENTS		0	0			73.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL	SERVI CES	0	0			76. 00
76. 01 03950 DI ABETI C EDUCATION		0	0			76. 01
OUTPATIENT SERVICE COST CENTERS			<u> </u>			01 00

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91. 00 | 09100 | EMERGENCY | 92. 00 | 09200 | 09SERVATI ON BEDS (NON-DI STI NCT PART

200.00

201.00

202.00

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
Net Charges (line 200 - line 201)

Health Financial Systems	TAYLORVILLE MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1339	Peri od: From 10/01/2018	Worksheet D-1
		To 09/30/2019	Date/Time Prepared: 2/26/2020 1:37 pm
	Title XVIII	Hospi tal	Cost

Death I and is permitted the provided of the p	-		Title XVIII	Hospi tal	2/26/2020 1: 3 Cost	7 pm
NATE IN COMPARISON NATE OF COMPONENTS		Cost Center Description	I tile XVIII	поѕрі таі	Cost	
NeATHERT DAYS					1. 00	
Impatient days (including private room days and swing-bed days, excluding newborn) 5,232 1.00						
Impattent days (including private room days, excluding saing-bed and newborn days) 2, 008	1 00		avaluding nawharm)		F 222	1 00
Private room days (excluding swing-bed and observation bed days). If you have only private room days. do do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days) through December 31 of the cost 65 5.00 Total swing-bed SMF type inpatient days. (including private room days) through December 31 of the cost 7.00 Total swing-bed SMF type inpatient days. (including private room days) after December 31 of the cost 7.00 Total swing-bed NF type inpatient days. (including private room days) through December 31 of the cost 7.00 Total swing-bed NF type inpatient days. (including private room days) after December 31 of the cost 7.00 Total swing-bed NF type inpatient days. (including private room days) after December 31 of the cost 7.00 Total swing-bed NF type inpatient days. (including private room days) after December 31 of the cost 7.00 Total swing bed NF type inpatient days applicable to the Program (excluding swing-bed and 7.00 December 31 of the cost reporting period (including private room days) after 7.00 December 31 of the cost reporting period (including private room days) after 7.00 December 31 of the cost reporting period (including private room days) after 7.00 December 31 of the cost reporting period (including private room days) after 7.00 December 31 of the cost reporting period (including private room days) after 8.00 December 31 of the cost reporting period (including private room days) after 8.00 December 31 of the cost reporting period (including private room days) after 8.00 December 31 of the cost reporting period (including private room days) after 8.00 December 31 of the cost reporting period (including private room days) after 8.00 December 31 of the cost reporting period (including private room days) after 8.00 December 31 of the cost reporting period (including private room days) after 8.00 December 31 of the cost reporting period (including private room days) after 8.00 December 31 of the cost reporting period (including private room days) after 8.00 D						
do not complete this line. 4. 05 Sein-private room days (sectualing swing-bed and observation bed days) 1. 10 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total sing-bed SW type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. 00 Total sing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total sing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. 05 Sing-bed SW type inpatient days applicable to the Program (excluding private room days) 10. 05 Sing-bed SW type inpatient days applicable to the Program (excluding private room days) 10. 05 Sing-bed SW type inpatient days applicable to the SW type inpatient days applicable to the Program (excluding private room days) 10. 05 Sing-bed SW type inpatient days applicable to the SW type inpatient days applicable to SW type in			3 /	ivate room davs.	· ·	
Total sawing-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) 7.00 Intel 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) 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) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.01 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.03 Sung-bed SNF type inpatient days applicable to the Program (excluding swing-bed and 1.653 9.00 Sung-bed SNF type inpatient days applicable to the Program (excluding sprivate room days) 11.00 Swing-bed SNF type inpatient days applicable to title SVIII only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to title SVIII only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 15.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 16.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 17.00 Wedicard Processor (title V or XIX only) 18.00 Swing-bed SNF type inpatient days applicable to services through December 31 of the cost reporting period (including type-bed SNF services applicable to services through December 31 of the cost reporting period (including SNF services applicable to services after December 31 of the cost reporting period (line SNF services after December 31 of the cost reporting period (line SNF services after D			3	,		
reporting period (if calendar year, enter 0 on this line) 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.0						
1.00 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 I ine) 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 I ine) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (in patient days including private room days) after December 31 of the cost reporting period (in patient days including private room days) Total swing-bed and reporting period (see instructions) Total swing-bed and reporting period (see instructions) Total swing-bed and reporting period (see instructions) Total swing-bed and reporting period (if calendar year, enter 0 on this I ine) Total swing-bed NF type inpatient days applicable to title XVII only (including private room days) Total Swing-bed NF type inpatient days applicable to title XVII only (including private room days) Total Swing-bed NF type inpatient days applicable to title XVII only (including private room days) Total Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) Total Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) Total Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) Total Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) Total Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) Total Swing-bed NF type inpatient days applicable to services through December 31 of the cost reporting period Total Swing-bed NF type inpatient days applicable to services after December 31 of the cost reporting period Total Swing-bed NF type inpatient days applicable to services after December 31 of the cost reporting period Total Swing-bed NF type inpatient routine service cost (see	5.00		om days) through December	r 31 of the cost	665	5.00
reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed Ni Type Inpatient days (Including private room days) through December 31 of the cost 124 8. 00 10 Total Inpation (if calendar year, enter 0 on this line) 9. 00 Total Inpation (if calendar year, enter 0 on this line) 10. 00 Swing-bed SNF type Inpatient days applicable to the Program (excluding swing-bed and newborn days) 11. 00 Swing-bed SNF type Inpatient days applicable to the Program (excluding swing-bed and newborn days) 11. 00 Swing-bed SNF type Inpatient days applicable to the View of through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12. 0. 0. Swing-bed SNF type Inpatient days applicable to title XVIII only (Including private room days) 13. 0. 0. Swing-bed SNF type Inpatient days applicable to the Program (excluding swing-bed and newborn days) 14. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.	6 00		om davs) after December :	31 of the cost	1 994	6.00
reporting period 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) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Swing-bed SNB type inpatient days applicable to title XVIII only (including private room days) 505 10. 00 Swing-bed SNB type inpatient days applicable to title XVIII only (including private room days) after become and in the cost reporting period (see instructions) 11. 00 Swing-bed SNB type inpatient days applicable to title XVIII only (including private room days) after become 31 of the cost reporting period (alendar year, enter 0 on this line) 12. 00 Swing-bed SNB type inpatient days applicable to titles V or XIX only (including private room days) 13. 00 Swing-bed SNB type inpatient days applicable to titles V or XIX only (including private room days) 14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15. 00 Total nursary days (ittle V or XIX only) 16. 00 Swing-bed SNB type inpatient days applicable to the Program (excluding swing-bed days) 17. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 18. 00 Total nursary days (ittle V or XIX only) 19. 00 SNB	0.00		siii daye, a. te. Beeeiiibei	0. 0. 1 0001	.,	0.00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (incl calendar year, enter 0 on this line)	7.00		n days) through December	31 of the cost	41	7. 00
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) 13.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after Exception of through December 31 of the cost reporting period (including private room days) after 50 miles 50 mi	0 00		days) after December 2	1 of the cost	124	0 00
1.00 North 1.00	8.00		ii days) ai tei beceiibei 3	i or the cost	124	8.00
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after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 16.00 17.00 Nover yeays (title V or XIX only) 18.00 Nover yeays (title V or xIX only) 19.00 Nover yeays (title V or xIX only) 19.00 Nover yeavs (title V or xIX only) 20.00 Nover years (year year) 20.00 Nover years (year) 20.00 Nover years (year) 20.00 Nover yeavs (year) 20.00 Nover yeavs (year) 20.00 Nover years (year) 20	13 00	1 31	(only (including private	e room days)	l 0	13 00
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16.00 Nursery days (title V or XIX only) 17.00 Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting perio	14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
SWING BED ADJUSTMENT 17. 00 18. 00 18. 00 18. 00 19. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period reporting period medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period reporting					0	
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	Financial Systems TATION OF INPATIENT OPERATING COST	TAYLORVILLE MEMO		CN: 14-1339	In Lie Period:	u of Form CMS-: Worksheet D-1	
COMITO	ATTON OF THE ATTENT OF ENATING COST		Trovider c	CN. 14-1337	From 10/01/2018 To 09/30/2019	Date/Time Pre	pared:
			Ti tl e	e XVIII	Hospi tal	2/26/2020 1:3 Cost	7 pm
	Cost Center Description	Total Inpatient Cost	Total	Average Per	Program Days	Program Cost (col. 3 x col.	
		1.00	2. 00	3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)		2.00	3.00	4. 00	3. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Uni INTENSIVE CARE UNIT	ts					42.00
43. 00 44. 00	CORONARY CARE UNIT						43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	1						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
						1. 00	
48. 00	Program inpatient ancillary service cost (nc)		1, 353, 103	
49. 00	Total Program inpatient costs (sum of line PASS THROUGH COST ADJUSTMENTS	S 41 through 48)(see mstructio	nis)		3, 784, 964	49. 00
50. 00	Pass through costs applicable to Program i	npatient routine	services (from	n Wkst. D, su	m of Parts I and	0	50. 00
51. 00		nnationt ancillar	v sorvicos (fr	com Wkst D	cum of Darte II	0	51.00
31.00	and IV)	ilpatrent anciliai	y services (ii	OII WKSt. D,	sum of farts fr	0	31.00
52.00	Total Program excludable cost (sum of line					0	
53. 00	Total Program inpatient operating cost exc medical education costs (line 49 minus lin		lated, non-phy	sician anesti	netist, and	0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	0 02)					
	Program di scharges						54.00
56. 00	Target amount per discharge Target amount (line 54 x line 55)						55. 00 56. 00
57. 00	,	ating cost and ta	rget amount (I	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost market basket	reporting period	endi ng 1996, ι	updated and c	ompounded by the	0. 00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior yea	r cost report, up	dated by the m	narket basket		0.00	60.00
61. 00						0	61. 00
	which operating costs (line 53) are less t amount (line 56), otherwise enter zero (se		s (lines 54 x	60), or 1% o	t the target		
62.00 Relief payment (see instructions)							62. 00
63. 00	Allowable Inpatient cost plus incentive pa	yment (see instru	ctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine c	osts through Dece	mber 31 of the	e cost report	ng period (See	742, 946	64. 00
	instructions)(title XVIII only)		04 6 11			0 000 000	/ = 00
65. 00	Medicare swing-bed SNF inpatient routine c instructions) (title XVIII only)	osts after Decemb	er 31 or the c	cost reportin	g period (See	2, 228, 838	65.00
66. 00	Total Medicare swing-bed SNF inpatient rou	tine costs (line	64 plus line 6	55)(title XVI	II only). For	2, 971, 784	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient rout	ine costs through	December 31 o	of the cost r	eporting period	0	67. 00
	(line 12 x line 19)	9					
68. 00	Title V or XIX swing-bed NF inpatient rout (line 13 x line 20)	ine costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatien	t routine costs (line 67 + line	e 68)		0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER				\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		70.00
70. 00 71. 00	Skilled nursing facility/other nursing fac Adjusted general inpatient routine service	,		•)		70.00
72. 00				-,			72. 00
73.00	Medically necessary private room cost appl						73.00
74. 00 75. 00	Total Program general inpatient routine se Capital-related cost allocated to inpatien	•			Part II column		74. 00 75. 00
70.00	26, line 45)				a. c ,		70.00
76.00	Per diem capital related costs (line 75 ÷	. *					76.00
77. 00 78. 00	Program capital-related costs (line 9 x li Inpatient routine service cost (line 74 mi						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exc		rovi der record	ds)			79. 00
	Total Program routine service costs for co	•	ost limitation	n (line 78 mi	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem li Inpatient routine service cost limitation)				81.00
83. 00	Reasonable inpatient routine service costs	•	•				83.00
84. 00	Program inpatient ancillary services (see	•	-				84.00
85. 00	Utilization review - physician compensatio						85.00
86. 00	Total Program inpatient operating costs (s PART IV - COMPUTATION OF OBSERVATION BED PART IV - COMPUTATION OF OBSERVATION BED PART IV		rough 85)				86. 00
87. 00	Total observation bed days (see instruction					253	87. 00
88. 00	Adjusted general inpatient routine cost pe Observation bed cost (line 87 x line 88) (•	line 2)			1, 471. 19 372, 211	
00 00							

Health Financial Systems T	AYLORVILLE MEMO	ORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2018 To 09/30/2019		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(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	673, 565	7, 480, 425	0. 09004	4 372, 211	33, 515	90.00
91.00 Nursing School cost	0	7, 480, 425	0.00000	372, 211	0	91.00
92.00 Allied health cost	0	7, 480, 425	0.00000	372, 211	0	92.00
93.00 All other Medical Education	0	7, 480, 425	0. 00000	372, 211	0	93. 00

Health Fina	ncial Systems	TAYLORVILLE MEMORIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT A	NCILLARY SERVICE COST APPORTIONMENT	Provi der CO	CN: 14-1339	Peri od: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Pre	
				10 09/30/2019	2/26/2020 1:3	
		Title	XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
LNDAT	TIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	O ADULTS & PEDIATRICS			2, 545, 949		30.00
	LLARY SERVICE COST CENTERS			2, 545, 747	l	30.00
	O OPERATING ROOM		0. 70722	27 221, 511	156, 659	50.00
	O ANESTHESI OLOGY		0. 50624			1
54.00 05400	O RADI OLOGY-DI AGNOSTI C		0. 10637			54.00
60.00 06000	O LABORATORY		0. 25679	1, 135, 003	291, 460	60.00
64.00 06400	O INTRAVENOUS THERAPY		0. 16796	1, 756	295	64. 00
	RESPIRATORY THERAPY		0. 33262		212, 511	65. 00
	O PHYSI CAL THERAPY		0. 49621			
	O OCCUPATI ONAL THERAPY		0. 43678	· ·		1
	O SPEECH PATHOLOGY		0. 27649			1
	O ELECTROCARDI OLOGY		0. 18782	· ·		1
	O MEDICAL SUPPLIES CHARGED TO PATIENT		0. 19439	· ·		1
	O IMPL. DEV. CHARGED TO PATIENTS		0. 24772			
	DRUGS CHARGED TO PATIENTS		0. 30369	· ·		
	O PSYCHIATRIC/PSYCHOLOGICAL SERVICES		1. 11177 0. 38359		1 250	
	O DIABETIC EDUCATION ATIENT SERVICE COST CENTERS		0.3835	90 3,519	1, 350	76.01
91. 00 0910			0. 36635	54 0	0	91.00
	O OBSERVATION BEDS (NON-DISTINCT PART		0. 36739		0	1
200.00	Total (sum of lines 50 through 94 ar	nd 96 through 98)	0.0070	5, 076, 823		
201.00	Less PBP Clinic Laboratory Services-			0, 0, 0, 020		201.00
202. 00	Net charges (line 200 minus line 201			5, 076, 823	l	202.00
1	3	•	'		•	

Heal th	Financial Systems TAYLORVILLE MEMORIA	AL HOSPITAL		In Li∈	u of Form CMS-2	2552-10
	NT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 14-1339	Peri od:	Worksheet D-3	
		Component	CCN: 14-Z339	From 10/01/2018 To 09/30/2019	2/26/2020 1:3	
		Titl∈		Swing Beds - SNF		
	Cost Center Description		Ratio of Cos	r r r r r	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
μ.	INPATIENT ROUTINE SERVICE COST CENTERS		l			
	03000 ADULTS & PEDI ATRI CS			0		30.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATI NG ROOM		0. 70722		5, 128	
	05300 ANESTHESI OLOGY		0. 50624		0	
	05400 RADI OLOGY-DI AGNOSTI C		0. 10637		24, 811	
	06000 LABORATORY		0. 25679		124, 189	
	06400 I NTRAVENOUS THERAPY		0. 16796		0	64.00
	06500 RESPI RATORY THERAPY		0. 33262		113, 421	65. 00
	06600 PHYSI CAL THERAPY		0. 4962		· ·	
	06700 OCCUPATI ONAL THERAPY		0. 43678		231, 448	
	06800 SPEECH PATHOLOGY		0. 27649			
	06900 ELECTROCARDI OLOGY		0. 18782			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 19439		21, 490	
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 24772		0	72. 00
	07300 DRUGS CHARGED TO PATIENTS		0. 30369		175, 763	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		1. 11177		0	76. 00
	03950 DI ABETI C EDUCATION		0. 38359	90 0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS					
	09100 EMERGENCY		0. 36635		0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 36739		0	92. 00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			2, 915, 077		
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202. 00	Net charges (line 200 minus line 201)		l	2, 915, 077		202. 00

Health Financial Syst	ems	TAYLORVILLE MEMORIA	AL HOSPITAL		In	Lieu of Form CMS-2552-10
CALCULATION OF REIMBU	JRSEMENT SETTLEMENT		Provider CCN	: 14-1339	Peri od: From 10/01/20 To 09/30/20	Worksheet E Part B Date/Time Prepared: 2/26/2020 1:37 pm

			10 09/30/2019	2/26/2020 1:3	
		Title XVIII	Hospi tal	Cost	7 рііі
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			9, 311, 808	1
2.00	Medical and other services reimbursed under OPPS (see instruc	ti ons)		0	
3. 00					
4.00	Outlier payment (see instructions)			0	
4. 01	Outlier reconciliation amount (see instructions)	-+:>		0	
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instructions 2 times line 5	ctions)		0.000	1
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8. 00	Transitional corridor payment (see instructions)			0.00	1
9. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV col 13 line 200		0	
10.00	Organ acquisitions	14, 661. 16, 11116 266		o o	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			9, 311, 808	
	COMPUTATION OF LESSER OF COST OR CHARGES			, . ,	
	Reasonable charges				1
12.00	Ancillary service charges			0	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ine 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
	Customary charges				1
15. 00	Aggregate amount actually collected from patients liable for p			0	
16. 00	Amounts that would have been realized from patients liable for	1 3	n a chargebasis	0	16. 00
17 00	had such payment been made in accordance with 42 CFR §413.13(e)		0 000000	17 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0.000000	1
19. 00	Excess of customary charges over reasonable cost (complete only	Ly if line 18 exceeds lin	na 11) (saa	0	1
19.00	instructions)	Ty IT Time to exceeds ITI	ic 11) (366		19.00
20. 00	Excess of reasonable cost over customary charges (complete on	lvifline 11 exceeds lir	ne 18) (see	0	20.00
	instructions)	. ,	, (
21.00	Lesser of cost or charges (see instructions)			9, 404, 926	21.00
22.00	Interns and residents (see instructions)			0	22. 00
23.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions	•		64, 011	1
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on line Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)]			6, 191, 111 3, 149, 804	
27.00	instructions)	prus the sum of fittes 22	and 23] (See	3, 149, 604	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ine 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			Ō	1
30.00	Subtotal (sum of lines 27 through 29)			3, 149, 804	30.00
31.00	Primary payer payments			307	31.00
32.00	Subtotal (line 30 minus line 31)			3, 149, 497	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIO	CES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			1, 121, 816	1
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	musti sps)		729, 180	
	Subtotal (see instructions)	ructions)		991, 369 3, 878, 677	
	MSP-LCC reconciliation amount from PS&R			3, 676, 677	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		· ·	39. 50
39. 97	Demonstration payment adjustment amount before sequestration	-,		0	1
39. 98	Partial or full credits received from manufacturers for replacements	ced devices (see instruct	i ons)	Ö	1
	RECOVERY OF ACCELERATED DEPRECIATION	(222	,	o o	1
40.00	Subtotal (see instructions)			3, 878, 677	1
40. 01	Sequestration adjustment (see instructions)			77, 574	1
40. 02	Demonstration payment adjustment amount after sequestration			0	1
41.00	Interim payments			4, 948, 855	41.00
42.00	Tentative settlement (for contractors use only)			0	
43.00	Balance due provider/program (see instructions)			-1, 147, 752	
44.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2, o	chapter 1,	0	44.00
	§115. 2				1
00 00	TO BE COMPLETED BY CONTRACTOR			_	00.00
	Original outlier amount (see instructions)			0	1
91.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0.00	
92. 00 93. 00	Time Value of Money (see instructions)			0.00	1
	Total (sum of lines 91 and 93)				94.00
, 1. 00	1.00a. (Sum of Frings / and /s)			'	, , , , , ,

In Lieu of Form CMS-2552-10

| Period: | Worksheet E-1 |
| From 10/01/2018 | Part |
| To 09/30/2019 | Date/Time Prepared: | 2/26/2020 1:37 pm | Health Financial Systems TAYLOR ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 14-1339

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.						2/26/2020 1:37	7 pm
1.00			Title	XVIII	Hospi tal	Cost	•
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 1.00 1.101 interim payments payable on individual bills, either submitted or to be submitted to the contractor for submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 1.00 1			I npati en	t Part A	Par	rt B	
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1.00 Total interim payments paid to provider 3,394,597 4,886,360 1.00 1.00 1.00 1.00 1.00 1.00 2.00 1.00 1.00 1.00 2.00 1.00 1.00 2.00 1.00 2.00 1.00 2.00				2.00		4.00	
Submitted for to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero	1. 00	Total interim payments paid to provider			7	4, 886, 360	1. 00
Services rendered in the cost reporting period. If none, write "NOME" or enter a zero (1)	2.00						2. 00
Write "NONE" or enter a zero		submitted or to be submitted to the contractor for					
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)		services rendered in the cost reporting period. If none,					
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write inverted by the payment. If none, write inverted by the payment. If none, write inverted by the program to Provider and the payment after desk review. Also show date of each payment. If none, write involved to Program 5.00 List separately acon tenter a zero. (1) Program to Provider to Program ADJUSTMENTS TO PROGRAM O 0 0 0 0 3.50 Provider to Program ADJUSTMENTS TO PROGRAM O 0 0 0 0 3.50 3.51 5.52 0 0 0 0 3.55 3.54 0 0 0 3.55 3.55 0 0 0 3.55 3.54 0 0 0 3.55 3.55 0 0 0 3.55 3.56 0 0 0 3.55 3.57 0 0 0 3.55 3.58 0 0 0 3.55 3.59 0 0 0 3.55 3.50 0 0 3.55 3.50 0 0 0 3.55 3.50 0 0 0 3.55 3.50 0 0 0 3.55 3.50 0 0 0 3.55 3.50 0 0 0 3.55 3.50 0 0 0 3.55 3.50 0 0 0 3.55 3.50 0 0 0 3.55 3.50 0 0 0 0 3.55 3.50 0 0 0 0 3.55 3.50 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		write "NONE" or enter a zero					
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3. 00
Bayment. If none, write "NONE" or enter a zero. (1) Program to Provider		amount based on subsequent revision of the interim rate					
Program to Provider ADJUSTMENTS TO PROVIDER O4/11/2019 0215, 581 O4/11/2019 62, 495 3, 01 3, 02 09/03/2019 108, 727 0 3, 02 3, 03 3, 04 0 0 0 3, 04 3, 05 0 0 0 3, 04 3, 05 0 0 0 3, 04 3, 05 0 0 0 3, 04 3, 05 0 0 0 3, 04 3, 05 0 0 0 3, 04 3, 05 3, 05 0 0 0 3, 05 3, 05 3, 05 0 0 0 0, 0 3, 51 3, 52 0 0 0 0, 0 3, 51 3, 53 0 0 0 0, 0 3, 51 3, 53 0 0 0 0, 0 3, 53 3, 53 0 0 0 0, 0 3, 53 3, 53 0 0 0 0, 0 3, 53 3, 53 0 0 0 0, 0 3, 53 3, 53 0 0 0 0, 0 3, 53 3, 53 0 0 0 0, 0 3, 53 3, 53 0 0 0 0, 0 3, 53 3, 54 0 0 0 0, 0 3, 53 3, 54 0 0 0 0, 0 3, 53 3, 54 0 0 0 0, 0 3, 55 3, 59 3, 50, 3, 98 0 0 0 0, 0 3, 55 4, 948, 855 4, 00 0 0 0 0 0, 0 0, 0 0 0, 0							
ADJUSTMENTS TO PROVIDER							
3.02 09/03/2019 108,727 0 3.02 0 0 0 3.02 0 0 0 3.02 0 0 0 3.03 0 0 0 3.04 0 0 0 3.05 0 0 0 0 3.05 0 0 0 0 0 0 0 0 0							
3.04 3.05 3.04 3.05 3.06 3.06 3.07 3.08 3.09 3.09 3.09 3.09 3.00 3.00 3.00 3.00		ADJUSTMENTS TO PROVIDER					
3.04 0 0 0 3.04 3.05 3.06 0 0 0 3.05 3.05 3.50 3.51 3.52 0 0 0 3.51 3.52 0 0 0 3.53 3.53 3.53 3.54 0 0 0 3.53 3.54 3.99 3.50 3.50 3.50 3.5			09/03/2019			- 1	
3. 50					-	1	
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.50 3.50 3.50 0 0 0 3.51 3.52 0 0 0 0 3.53 3.53 0 0 0 0 3.53 3.53 3.54 0 0 0 3.53 3.54 3.59 3.50 3							
3. 50 ADJUSTMENTS TO PROGRAM	3.05					0	3. 05
3.51 0					_		
3.52 3.53 3.54 3.99 3.50 3.60 3.50		ADJUSTMENTS TO PROGRAM			-	1	
3.53 3.54 3.59 3.59 3.50-3.98 3.50-3.98 3.50-3.99 3.50-3.99 3.50-3.99 3.50-3.99 3.718,905 4.948,855 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) 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) Program to Provider TETNATIVE TO PROVIDER 0 0 5.02 5.03 Provider to Program TENTATIVE TO PROGRAM 0 0 5.51 5.51 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 5.50-5.98 6.00 Determined net settlement amount (balance due) based on the cost report. (1) Cost Contractor Contractor Contractor Contractor Contractor Contractor NPR Date (Mo/Day/Yrr) Contractor					-	1 - 1	
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.24, 308 62, 495 3.99 3.50-3.98) 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) TO BE COMPLETED BY CONTRACTOR							
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 3,718,905 4,948,855 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR					-	1 - 1	
3. 50-3. 98 Total interim payments (sum of lines 1, 2, and 3. 99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To Be COMPLETED BY CONTRACTOR					-	1 - 1	
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) TO BE COMPLETED BY CONTRACTOR	3. 99			324, 308	3	62, 495	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		1 2 2 2 2 2 2					
appropriate TO BE COMPLETED BY CONTRACTOR	4.00			3, 718, 90!		4, 948, 855	4. 00
TO BE COMPLETED BY CONTRACTOR S. 00							
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) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	г оо		I		1		г оо
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5.00
Program to Provider							
TENTATI VE TO PROVIDER		Program to Provider					
5. 02 0	5 01			T (0	5 01
Solution Settlement amount (balance due) based on the cost report. (1) Settlement TO PROGRAM S		TENTATI VE TO TROVIDER					
Provider to Program							
TENTATIVE TO PROGRAM 0	0.00	Provider to Program		,	21		0.00
5.51 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 50					0	5. 50
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00						0	
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)							5. 52
5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00		Subtotal (sum of lines 5.01-5.49 minus sum of lines				1	
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	0. , ,	· ·		· ·			0. ,,
the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00	6.00						6. 00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	00	,					2. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 343, 323 3, 375, 582 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6. 01					l ol	6. 01
7.00 Total Medicare program liability (see instructions) 3,375,582 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				343. 32	3	1, 147, 752	6. 02
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00							
Number (Mo/Day/Yr) 0 1.00 2.00		,		2, 2. 2, 00.			
0 1.00 2.00							
8.00 Name of Contractor 8.00			()	1. 00		
	8. 00	Name of Contractor					8. 00

Health Financial Systems TAYLOR ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		'			2/26/2020 1: 3	7 pm
				wing Beds - SNF		
		Inpatien	t Part A	Par	t 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		3, 675, 301		0	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	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)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	04/11/2019	162, 744		0	3. 01
3.02		09/03/2019	59, 808		0	3. 02
3.03			0		0	3. 03
3. 04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program			1		
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3. 54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		222, 552		0	3. 99
4 00	3. 50-3. 98)		0 007 050			4 00
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 897, 853		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			l o		o	5. 02
5. 03			0		o	5. 03
	Provider to Program				-	
5.50	TENTATI VE 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		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		70, 002		0	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 827, 851		0	7. 00
				Contractor	NPR Date	
			2	Number	(Mo/Day/Yr)	
9.00	Name of Contractor)	1. 00	2. 00	0 00
8. 00	Name of Contractor	1				8. 00

Heal th	Financial Systems TAYLORVILLE MEMORI	AL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 14-1339 Period:				
			From 10/01/2018 To 09/30/2019		narod:
			10 09/30/2019	2/26/2020 1: 3	
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	14	I	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12		I	2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			I	3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12		I	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			I	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20		I	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c		Wkst. S-2, Pt. I	I	7. 00
	line 168	03		I	
8.00	Calculation of the HIT incentive payment (see instructions)			I	8. 00
9.00	Sequestration adjustment amount (see instructions)			I	9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		I	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,			1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)			I	31.00
	200 Deligned due providen (Line 10 (an Line 10) minus Line 20 and Line 21) (assignment and				

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

Health Financial Systems	TAYLORVILLE MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 14-1339	Peri od:	Worksheet E-2
			From 10/01/2018	
		Component CCN: 14-Z339	To 09/30/2019	Date/Time Prepared:
		·		2/26/2020 1:37 pm

		Component CCN: 14-2339	10 09/30/2019	2/26/2020 1:3	
		Title XVIII	Swing Beds - SNF		
	· · · · · · · · · · · · · · · · · · ·		Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		3, 001, 502	0	
2.00	Inpatient routine services - swing bed-NF (see instructions)		201.015		2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		986, 065	0	3. 00
4.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins Per diem cost for interns and residents not in approved teachi			0.00	4.00
4.00	instructions)	ing program (see		0.00	4.00
5.00	Program days		2, 020	0	5. 00
6. 00	Interns and residents not in approved teaching program (see in	structions)	_, -, -, -,	0	
7.00	Utilization review - physician compensation - SNF optional met	•	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		3, 987, 567	0	8.00
9.00	Primary payer payments (see instructions)		12, 447	0	9. 00
10.00	Subtotal (line 8 minus line 9)		3, 975, 120	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applic	able to physician	0	0	11. 00
	professi onal servi ces)				
12.00	Subtotal (line 10 minus line 11)		3, 975, 120	0	
13. 00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	69, 150	0	13. 00
14 00	for physician professional services)			0	14 00
14. 00 15. 00	80% of Part B costs (line 12 x 80%)	4)	2 005 070	0	
16. 00	Subtotal (enter the lesser of line 12 minus line 13, or line 1 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	4)	3, 905, 970	0	16.00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions)		U	16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr		0		16. 55
10. 55	adjustment (see instructions)	atton, payment			10. 55
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
	Allowable bad debts (see instructions)		0	0	1
	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18.00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)	0	0	18. 00
19.00	Total (see instructions)		3, 905, 970	0	19.00
	Sequestration adjustment (see instructions)		78, 119	0	
	Demonstration payment adjustment amount after sequestration)		0	0	
20. 00	Interim payments		3, 897, 853	0	
	Tentative settlement (for contractor use only)	1.04)	70,000	0	
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, a		-70, 002	0	
23. 00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstra	ation) Adjustment			
200 00	Is this the first year of the current 5-year demonstration per				200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	rod dilder the 21st			200.00
	Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from W	kst. D-1, Pt. II, line			201. 00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	Wkst. D-3, col. 3, lir	ne		202. 00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203. 00
204.00	Medicare swing-bed SNF discharges (see instructions)				204. 00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	ent 5-year demonst	ration	
205 00	period) Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mes line 204)			206. 00
200.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse				1200.00
207 00	Program reimbursement under the \$410A Demonstration (see instr				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2		1		208. 00
	and 3)	,,			
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	tions)			209.00
	Reserved for future use	-			210.00
	Comparision of PPS versus Cost Reimbursement		,		
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	09 plus line 210) (see			215. 00
	instructions)				

Health Financial Systems	TAYLORVILLE MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1339	Peri od: From 10/01/2018 To 09/30/2019		pared:
	Title XVIII	Hospi tal	Cost	
			1. 00	
DADT V CALCULATION OF DELMBURGEMENT SETTING	EMENT FOR MEDICADE DART A SERVICES COST	DELMDLIDGEMENT		

		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PAR	T A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			3, 784, 964	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0	2.00
3.00	Organ acquisition			o	3.00
4.00	Subtotal (sum of lines 1 through 3)			3, 784, 964	4.00
5.00	Primary payer payments			2, 516	
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3, 820, 298	
	COMPUTATION OF LESSER OF COST OR CHARGES			0, 000, 000	
	Reasonable charges				
7.00	Routine service charges			0	7. 00
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	10.00
	Customary charges		,		
11.00	Aggregate amount actually collected from patients liable for paym	ent for services on a	charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for pa	yment for services on	a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e)				
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13.00
14.00	Total customary charges (see instructions)			0	14.00
15.00	Excess of customary charges over reasonable cost (complete only i	f line 14 exceeds lin	e 6) (see	0	15.00
	instructions)				
16. 00	Excess of reasonable cost over customary charges (complete only i	fline 6 exceeds line	14) (see	0	16.00
	instructions)				
17. 00	Cost of physicians' services in a teaching hospital (see instruct	i ons)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		1	_	
18. 00	Direct graduate medical education payments (from Worksheet E-4, I	ine 49)		0	
19. 00	Cost of covered services (sum of lines 6, 17 and 18)			3, 820, 298	
20.00	Deductibles (exclude professional component)			438, 628	
21. 00	Excess reasonable cost (from line 16)			0	
22. 00	Subtotal (line 19 minus line 20 and 21)			3, 381, 670	
23. 00	Coinsurance			4, 092	
24. 00	Subtotal (line 22 minus line 23)			3, 377, 578	
25. 00	Allowable bad debts (exclude bad debts for professional services)	(see instructions)		102, 912	
26. 00	Adjusted reimbursable bad debts (see instructions)			66, 893	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instruct	irons)		87, 311	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			3, 444, 471	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.00	Subtotal (see instructions)			3, 444, 471	
30. 01	Sequestration adjustment (see instructions)			68, 889	
30. 02	Demonstration payment adjustment amount after sequestration			0	
31.00	Interim payments Tentative settlement (for contractor use only)			3, 718, 905	31. 00 32. 00
32.00	Tentative settlement (for contractor use only)	11 and 22)		242 222	
33. 00 34. 00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 3		hantar 1	-343, 323 0	33. 00 34. 00
34.00	Protested amounts (nonallowable cost report items) in accordance §115.2	WI LII CWS PUD. 13-2, C	партег г,	ا	34.00
	3110.2		ı	l	

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

Provider CCN: 14-1339

Peri od: Worksheet G From 10/01/2018 To 09/30/2019 Date/Ti me Prepared: 2/26/2020 1:37 pm

		General Fund	Speci fi c	Endowment Fund	2/26/2020 1:3 Plant Fund	/ pm
			Purpose Fund			
	CURRENT ACCETS	1.00	2. 00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	6, 997, 837		ol ol	0	1.00
2. 00	Temporary investments	298, 006		-	0	
3.00	Notes recei vable	6, 952, 852		o	0	3. 00
4.00	Accounts receivable	0	C	o	0	
5. 00	Other recei vable	415, 573		0	0	1
6.00	Allowances for uncollectible notes and accounts receivable	-1, 808, 665			0	6.00
7. 00 8. 00	Inventory Prepai d expenses	385, 929 495, 686			0	7. 00 8. 00
9. 00	Other current assets	475,000			0	
10. 00	Due from other funds	699, 444		ol ol	0	10.00
11. 00	Total current assets (sum of lines 1-10)	14, 436, 662	C	0	0	11. 00
	FIXED ASSETS					
12.00	Land	948, 070			0	1
13.00	Land improvements	4, 162, 150			0	13.00
14. 00 15. 00	Accumulated depreciation Buildings	-1, 831, 739 25, 904, 891		-	0	14. 00 15. 00
16. 00	Accumulated depreciation	-14, 438, 499	1		0	16.00
17. 00	Leasehold improvements	0	d	o	0	17. 00
18.00	Accumulated depreciation	0	C	ol ol	0	18. 00
19. 00	Fi xed equipment	0	C	이	0	19. 00
20. 00	Accumulated depreciation	0	C	0	0	20. 00
21. 00	Automobiles and trucks	0			0	21.00
22. 00 23. 00	Accumulated depreciation Major movable equipment	24, 429, 922			0	22. 00 23. 00
24. 00	Accumulated depreciation	-22, 583, 505			0	24.00
25. 00	Mi nor equi pment depreci abl e	0		ol ol	0	25. 00
26.00	Accumul ated depreciation	0	C	o	0	26. 00
27. 00	HIT designated Assets	0	C	o	0	27. 00
28. 00	Accumul ated depreciation	0	C	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	28, 597, 411		-	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	45, 188, 701		0	0	30.00
31. 00	Investments	35, 864, 281		ol	0	31.00
32. 00	Deposits on Leases	0		-	0	32. 00
33.00	Due from owners/officers	0	C	o	0	33. 00
34.00	Other assets	3, 509, 512	(o	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	39, 373, 793			0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	98, 999, 156	(0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	5, 217, 289		ol	0	37.00
38. 00	Salaries, wages, and fees payable	2, 648, 653		-	0	38.00
39. 00	Payrol I taxes payable	48	1	-	0	39. 00
40.00	Notes and Loans payable (short term)	455, 470	C	o	0	40. 00
41. 00	Deferred income	524, 563	C	o	0	41. 00
42. 00	Accel erated payments	0			_	42. 00
43. 00	Due to other funds	0			0	
44. 00 45. 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	3, 152, 054 11, 998, 077	1		0	
45.00	LONG TERM LIABILITIES	11, 770, 077		이 이		45.00
46. 00	Mortgage payable	0		ol ol	0	46. 00
47. 00	Notes payable	15, 552, 642	ď	o	0	47. 00
48.00	Unsecured Loans	0	C	o	0	48. 00
49. 00	Other long term liabilities	651, 590		-	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	16, 204, 232		-	0	
51. 00	Total liabilities (sum of lines 45 and 50)	28, 202, 309		0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	70, 796, 847	Ι			52.00
53. 00	Specific purpose fund	70, 770, 047				53.00
54. 00	Donor created - endowment fund balance - restricted			o		54.00
55.00	Donor created - endowment fund balance - unrestricted			o		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	70, 796, 847	(ا ا	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	98, 999, 156		1 1	0	
55. 55	[59]	,5,,,,,150]	O .	55. 55
		•		. '		•

Provider CCN: 14-1339

					То	09/30/2019	Date/Time Prep 2/26/2020 1:3	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	, piii
				·				
	T	1.00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		61, 080, 017			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9, 716, 830			_		2. 00
3.00	Total (sum of line 1 and line 2)		70, 796, 847			0		3. 00
4.00	Additions (credit adjustments) (specify)	0			0		0	4. 00
5.00		0			0		0	5. 00
6. 00 7. 00		0			0		0	6. 00 7. 00
7. 00 8. 00		0			0		0	7. 00 8. 00
9. 00					0		0	9. 00
10.00	Total additions (sum of line 4-9)	١	0		U	0	U	10.00
11. 00	Subtotal (line 3 plus line 10)		70, 796, 847			0		11. 00
12. 00	Deductions (debit adjustments) (specify)		10, 190, 041		0	U	0	12. 00
13. 00	beddetrons (debit adjustments) (specify)				0		0	13. 00
14. 00					0		0	14. 00
15. 00					0		0	15. 00
16. 00					0		0	16. 00
17. 00		l ol			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		70, 796, 847			0		19. 00
	sheet (line 11 minus line 18)							
		Endowment Fund	PI ant	Fund				
		4 00	7.00	9.00				
1 00	Fund hallances at beginning of period	6.00	7. 00	8. 00				1 00
1.00	Fund balances at beginning of period	6. 00	7. 00	8.00	0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		7. 00	8.00				2. 00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		7.00	8.00	0			2. 00 3. 00
2. 00 3. 00 4. 00	Net income (loss) (from Wkst. G-3, line 29)		7.00	8.00				2. 00 3. 00 4. 00
2.00 3.00 4.00 5.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		7.00	8.00				2. 00 3. 00 4. 00 5. 00
2.00 3.00 4.00 5.00 6.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		7. 00 0 0 0	8. 00				2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		7.00 0 0 0	8.00				2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2.00 3.00 4.00 5.00 6.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		7.00 0 0 0 0	8.00				2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		7.00 0 0 0 0	8.00				2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)		7.00 0 0 0 0	8.00	0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9)		7.00 0 0 0 0 0	8.00	0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		7.00 0 0 0 0 0	8.00	0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		7.00 0 0 0 0 0	8.00	0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		7.00 0 0 0 0 0	8.00	0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		7.00 0 0 0 0 0 0	8.00	0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)		7.00 0 0 0 0 0 0	8.00	0 0 0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)		7.00 0 0 0 0 0 0	8.00	0 0 0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance		7.00 0 0 0 0 0 0 0	8.00	0 0 0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)		7.00 0 0 0 0 0 0 0	8.00	0 0 0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00

Health Financial Systems TANSTATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-1339

			To	09/30/2019	Date/Time Prep 2/26/2020 1:3		
	Cost Center Description	Inpati	ent	Outpati ent	Total	, p	
		1.00		2. 00	3. 00		
	PART I - PATIENT REVENUES	-			0.00		
	General Inpatient Routine Services						
1.00					3, 459, 713	1.00	
2.00	SUBPROVI DER - I PF		59, 713			2.00	
3.00	SUBPROVI DER - I RF					3. 00	
4.00	SUBPROVI DER					4. 00	
5.00	Swing bed - SNF	2. 25	5, 922		2, 255, 922	5. 00	
6.00	Swing bed - NF		9, 988		139, 988	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			5, 623		5, 855, 623	10. 00	
	Intensive Care Type Inpatient Hospital Services	, , , ,			.,		
11. 00	INTENSIVE CARE UNIT					11. 00	
12.00	CORONARY CARE UNIT					12.00	
13.00	BURN INTENSIVE CARE UNIT					13.00	
14.00	SURGI CAL INTENSIVE CARE UNIT					14.00	
15.00						15.00	
16.00	Total intensive care type inpatient hospital services (sum of	lines	0		0	16.00	
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5, 85	5, 623		5, 855, 623	17.00	
18.00	Ancillary services	11, 59	2, 925	73, 927, 851	85, 520, 776	18.00	
19.00	Outpati ent servi ces	17	8, 419	16, 062, 302	16, 240, 721	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	HOSPI CE					26.00	
27. 00	PROFESSI ONAL FEES	19	95, 294	9, 110, 503	9, 305, 797	27.00	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst. 17,82	22, 261	99, 100, 656	116, 922, 917	28.00	
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			39, 727, 358		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		39, 727, 358		43.00	
	to Wkst. G-3, line 4)	I					

Heal th	Financial Systems TAYLORVILLE MEM	ORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
STATEM	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 14-1339 Period:			Worksheet G-3	
	From 10/01/2018 To 09/30/2019			Date/Time Prepared: 2/26/2020 1:37 pm	
				1. 00 116, 922, 917	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)				
2.00	Less contractual allowances and discounts on patients' accounts				2. 00
3. 00	Net patient revenues (line 1 minus line 2)			47, 923, 980	
4.00	Less total operating expenses (from Wkst. G-2, Part II, lir	ne 43)		39, 727, 358	
5.00	Net income from service to patients (line 3 minus line 4)			8, 196, 622	5. 00
	OTHER I NCOME			7.4.470	,
6.00	Contributions, donations, bequests, etc			74, 678	
7.00	Income from investments			1, 370, 781 0	
8.00	Revenues from telephone and other miscellaneous communication services				
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts				10.00
	Rebates and refunds of expenses			0	
	Parking lot receipts			0	
13.00	Revenue from laundry and linen service			0	13.00
	Revenue from meals sold to employees and guests			162, 667	
	Revenue from rental of living quarters			15.00	
	Revenue from sale of medical and surgical supplies to other	than patients			16. 00
	Revenue from sale of drugs to other than patients				17. 00
	Revenue from sale of medical records and abstracts				18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			-	19. 00
	Revenue from gifts, flowers, coffee shops, and canteen			0	
21. 00	Rental of vending machines			0	
22. 00	Rental of hospital space			0	
23. 00	Governmental appropriations			0	
	MI SCELLANEOUS I NCOME			18, 832	
	OTHER (SPECIFY)			0	
	Total other income (sum of lines 6-24)			1, 628, 388	
	Total (line 5 plus line 25)			9, 825, 010	
	LOSS ON BOND REFUNDING			108, 180	
	Total other expenses (sum of line 27 and subscripts)		108, 180 9, 716, 830		
29. 00	29.00 Net income (or loss) for the period (line 26 minus line 28)				