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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1339	Period: From 10/01/2019 To 09/30/2020	Worksheet S Parts I-III Date/Time Prepared: 3/26/2021 8:45 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 3/26/2021 Time: 8:45 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by TAYLORVILLE MEMORIAL HOSPITAL (14-1339) for the cost reporting period beginning 10/01/2019 and ending 09/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[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) KATHRYN KEIM
Officer or Administrator of Provider(s)

SENIOR VICE PRESIDENT & CFO
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-310,501	794,554	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	-5,623	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-316,124	794,554	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part I Date/Time Prepared: 3/26/2021 8:45 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 201 EAST PLEASANT STREET	PO Box:			1.00
2.00	City: TAYLORVILLE	State: IL	Zip Code: 62568	County: CHRISTIAN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	TAYLORVILLE MEMORIAL HOSPITAL	141339	99914	1	09/01/2004	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	TAYLORVILLE MEMORIAL-SWB	14Z339	99914		09/01/2004	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									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)	10/01/2019	09/30/2020	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part I Date/Time Prepared: 3/26/2021 8:45 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2.	N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part I | Date/Time Prepared: 3/26/2021 8:45 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part I Date/Time Prepared: 3/26/2021 8:45 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1339	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 3/26/2021 8:45 am

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part I Date/Time Prepared: 3/26/2021 8:45 am

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	23,050	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H058	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part I Date/Time Prepared: 3/26/2021 8:45 am

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: MEMORIAL HEALTH SYSTEMS	Contractor's Name: MEMORIAL HEALTH SYSTEMS	Contractor's Number: 00131	141.00
142.00	Street: 701 NORTH FIRST STREET	PO Box:		142.00
143.00	City: SPRINGFIELD	State: IL	Zip Code: 62781	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part II | Date/Time Prepared: 3/26/2021 8:45 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/22/2021	Y	03/22/2021	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-2 Part II Date/Time Prepared: 3/26/2021 8:45 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN		WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4300		KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1339	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part II Date/Time Prepared: 3/26/2021 8:45 am

		3.00			
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR			41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-3 Part I Date/Time Prepared: 3/26/2021 8:45 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	45,119.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	45,119.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,150	45,119.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-3 Part I | Date/Time Prepared: 3/26/2021 8:45 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,365	23	1,910			1.00
2.00	HMO and other (see instructions)	49	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	2,035	0	2,730			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	92			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,400	23	4,732			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	3,400	23	4,732	0.00	249.51	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	249.51	27.00
28.00	Observation Bed Days		0	217			28.00
29.00	Ambulance Trips	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 outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-3 Part I | Date/Time Prepared: 3/26/2021 8:45 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	321	7	480	1.00
2.00	HMO and other (see instructions)			14	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	321	7	480	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet S-10 | Date/Time Prepared: 3/26/2021 8:45 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.346448	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,917,190	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	19,700,498	6.00
7.00	Medicaid cost (line 1 times line 6)	6,825,198	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,908,008	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	46,878	9.00
10.00	Stand-alone CHIP charges	131,156	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	45,439	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,908,008	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	136,801	163,913	300,714	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	47,394	163,913	211,307	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,227	0	1,227	22.00
23.00	Cost of charity care (line 21 minus line 22)	46,167	163,913	210,080	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,781,457	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	576,151	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	886,385	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,895,072	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	966,778	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,176,858	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,084,866	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A | Date/Time Prepared: 3/26/2021 8:45 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,518,421	2,518,421	279,010	2,797,431	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,736,707	1,736,707	59,674	1,796,381	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	435,170	4,834,798	5,269,968	-21,868	5,248,100	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,339,148	5,008,061	7,347,209	-33,688	7,313,521	5.00
7.00	00700	OPERATION OF PLANT	793,655	807,876	1,601,531	0	1,601,531	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,089	142,064	162,153	0	162,153	8.00
9.00	00900	HOUSEKEEPING	391,199	82,948	474,147	0	474,147	9.00
10.00	01000	DIETARY	390,019	293,564	683,583	-449,113	234,470	10.00
11.00	01100	CAFETERIA	0	0	0	446,710	446,710	11.00
13.00	01300	NURSING ADMINISTRATION	627,550	17,141	644,691	0	644,691	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	114,761	88,412	203,173	-485	202,688	14.00
15.00	01500	PHARMACY	509,911	1,294,044	1,803,955	-1,225,544	578,411	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	427,549	6,998	434,547	0	434,547	16.00
17.00	01700	SOCIAL SERVICE	62,555	82	62,637	0	62,637	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	657,745	0	657,745	21,868	679,613	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,200,869	446,696	2,647,565	-229	2,647,336	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	620,622	609,092	1,229,714	-329,007	900,707	50.00
53.00	05300	ANESTHESIOLOGY	0	222,071	222,071	-10,973	211,098	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,225,784	685,070	1,910,854	-2,052	1,908,802	54.00
60.00	06000	LABORATORY	950,275	1,117,726	2,068,001	-118	2,067,883	60.00
64.00	06400	INTRAVENOUS THERAPY	126,947	16,175	143,122	-7	143,115	64.00
65.00	06500	RESPIRATORY THERAPY	505,852	82,637	588,489	-38,855	549,634	65.00
66.00	06600	PHYSICAL THERAPY	1,065,568	41,897	1,107,465	0	1,107,465	66.00
67.00	06700	OCCUPATIONAL THERAPY	306,280	3,964	310,244	0	310,244	67.00
68.00	06800	SPEECH PATHOLOGY	152,300	5,337	157,637	0	157,637	68.00
69.00	06900	ELECTROCARDIOLOGY	141,587	6,024	147,611	-6	147,605	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	101,833	101,833	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	290,930	290,930	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,229,781	1,229,781	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	165,791	112,417	278,208	0	278,208	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	2,403	2,403	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,649,317	2,895,918	4,545,235	-15,268	4,529,967	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		304,996	304,996	-304,996	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,880,543	23,381,136	39,261,679	0	39,261,679	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,756	1,756	0	1,756	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	15,880,543	23,382,892	39,263,435	0	39,263,435	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A | Date/Time Prepared: 3/26/2021 8:45 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-647,676	2,149,755		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	101,530	1,897,911		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	212,101	5,460,201		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-967,587	6,345,934		5.00
7.00	00700	OPERATION OF PLANT	-9,688	1,591,843		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	162,153		8.00
9.00	00900	HOUSEKEEPING	0	474,147		9.00
10.00	01000	DIETARY	0	234,470		10.00
11.00	01100	CAFETERIA	-112,752	333,958		11.00
13.00	01300	NURSING ADMINISTRATION	-286	644,405		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	202,688		14.00
15.00	01500	PHARMACY	0	578,411		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,885	428,662		16.00
17.00	01700	SOCIAL SERVICE	0	62,637		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-679,613	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-224,850	2,422,486		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-33,704	867,003		50.00
53.00	05300	ANESTHESIOLOGY	-146,156	64,942		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,908,802		54.00
60.00	06000	LABORATORY	0	2,067,883		60.00
64.00	06400	INTRAVENOUS THERAPY	0	143,115		64.00
65.00	06500	RESPIRATORY THERAPY	-1,045	548,589		65.00
66.00	06600	PHYSICAL THERAPY	0	1,107,465		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	310,244		67.00
68.00	06800	SPEECH PATHOLOGY	0	157,637		68.00
69.00	06900	ELECTROCARDIOLOGY	0	147,605		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	101,833		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	290,930		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,229,781		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	278,208		76.00
76.01	03950	DIABETIC EDUCATION	0	2,403		76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,815,964	2,714,003		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,331,575	34,930,104		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,756		192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,331,575	34,931,860		200.00

RECLASSIFICATIONS | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-6 | Date/Time Prepared: 3/26/2021 8:45 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA EXPENSE				
1.00	CAFETERIA	11.00	254,194	192,516	1.00
2.00	DIABETIC EDUCATION	76.01	2,403	0	2.00
	0		256,597	192,516	
	B - DRUG EXPENSE				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,229,781	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
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
	0		0	1,229,781	
	C - IMPLANTS & MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	101,833	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	290,930	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	392,763	
	D - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	33,688	1.00
	0		0	33,688	
	E - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	416,536	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	41,911	2.00
	0		0	458,447	
	F - BOND AMORTIZATION EXPENSE				
1.00	INTEREST EXPENSE	113.00	0	153,451	1.00
	0		0	153,451	
	G - CRNA BENEFITS				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	21,868	1.00
	0		0	21,868	
500.00	Grand Total: Increases		256,597	2,482,514	500.00

RECLASSIFICATIONS | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-6 | Date/Time Prepared: 3/26/2021 8:45 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	256,597	192,516	0		1.00
2.00		0.00	0	0	0		2.00
	0		256,597	192,516			
	B - DRUG EXPENSE						
1.00	PHARMACY	15.00	0	1,225,528	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	229	0		2.00
3.00	OPERATING ROOM	50.00	0	857	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	520	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,753	0		5.00
6.00	LABORATORY	60.00	0	118	0		6.00
7.00	INTRAVENOUS THERAPY	64.00	0	7	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	32	0		8.00
9.00	ELECTROCARDIOLOGY	69.00	0	6	0		9.00
10.00	EMERGENCY	91.00	0	731	0		10.00
	0		0	1,229,781			
	C - IMPLANTS & MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	485	0		1.00
2.00	PHARMACY	15.00	0	16	0		2.00
3.00	OPERATING ROOM	50.00	0	328,150	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	10,453	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	299	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	38,823	0		6.00
7.00	EMERGENCY	91.00	0	14,537	0		7.00
	0		0	392,763			
	D - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	33,688	0		1.00
	0		0	33,688			
	E - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	458,447	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	458,447			
	F - BOND AMORTIZATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	153,451	14		1.00
	0		0	153,451			
	G - CRNA BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	21,868	0		1.00
	0		0	21,868			
500.00	Grand Total: Decreases		256,597	2,482,514			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-7 Part I | Date/Time Prepared: 3/26/2021 8:45 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	948,070	110,625	0	110,625	0	1.00
2.00	Land Improvements	4,148,030	0	0	0	0	2.00
3.00	Buildings and Fixtures	25,904,891	0	0	0	9,137,312	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	24,429,922	244,788	0	244,788	164,000	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	55,430,913	355,413	0	355,413	9,301,312	8.00
9.00	Reconciling Items	-28,611,531	-18,150,737	0	-18,150,737	-328,954	9.00
10.00	Total (line 8 minus line 9)	84,042,444	18,506,150	0	18,506,150	9,630,266	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,058,695	0	1.00
2.00	Land Improvements	4,148,030	187,029	2.00
3.00	Buildings and Fixtures	16,767,579	1,289,825	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	24,510,710	16,898,278	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	46,485,014	18,375,132	8.00
9.00	Reconciling Items	-46,433,314	0	9.00
10.00	Total (line 8 minus line 9)	92,918,328	18,375,132	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-7 Part II | Date/Time Prepared: 3/26/2021 8:45 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,518,421	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,736,707	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,255,128	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	2,518,421		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,736,707		2.00
3.00	Total (sum of lines 1-2)	0	4,255,128		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-7 Part III Date/Time Prepared: 3/26/2021 8:45 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	21,974,304	0	21,974,304	0.472718	15,925	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	24,510,710	0	24,510,710	0.527282	17,763	2.00
3.00	Total (sum of lines 1-2)	46,485,014	0	46,485,014	1.000000	33,688	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	15,925	2,018,647	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	17,763	1,853,119	0	2.00
3.00	Total (sum of lines 1-2)	0	0	33,688	3,871,766	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	268,634	15,925	0	-153,451	2,149,755	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	27,029	17,763	0	0	1,897,911	2.00
3.00	Total (sum of lines 1-2)	295,663	33,688	0	-153,451	4,047,666	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-8 | Date/Time Prepared: 3/26/2021 8:45 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-147,902	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-14,882	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-3,278	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-6,195	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,688	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,484,086			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,070,640			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-112,752	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,885	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-558,504	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-679,613	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME - A&G	B	-3,582	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-8 | Date/Time Prepared: 3/26/2021 8:45 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC INCOME - NURSING ADMIN	B	-286	NURSING ADMINISTRATION	13.00	0	33.01
33.02	MISC INCOME - RT	B	-1,045	RESPIRATORY THERAPY	65.00	0	33.02
34.00	PROVIDER TAX	A	-1,311,416	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	MUTUAL FUND FEES	A	10,571	ADMINISTRATIVE & GENERAL	5.00	0	34.01
35.00	ADVERTISING EXPENSE	A	-54,776	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	LOBBYING EXPENSE	A	-18,896	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,331,575				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-8-1 | Date/Time Prepared: 3/26/2021 8:45 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HO NEW CAPITAL - BLDG	42,744	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO NEW CAPITAL - MME	2,871	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HO OTHER CAPITAL - BLDG	15,986	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO OTHER CAPITAL - MME	113,541	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HO INTEREST EXPENSE	9,233	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	HO MANAGEMENT OPERATING	2,012,990	1,338,826	4.02
4.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	2,804,582	2,592,481	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	A&G ITEMS - MMC	244,078	244,078	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,246,025	4,175,385	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B		0.00	MEMORIAL HEALTH	100.00	6.00
7.00	B		0.00	MEMORIAL MD CTR	0.00	7.00
8.00	B		0.00	ABRAHAM LINCOLN	0.00	8.00
9.00	B		0.00	MEMORIAL VNA	0.00	9.00
10.00	B		0.00	PASSAVANT	0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-8-1 | Date/Time Prepared: 3/26/2021 8:45 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	42,744	9		1.00
2.00	2,871	9		2.00
3.00	15,986	9		3.00
4.00	113,541	9		4.00
4.01	9,233	0		4.01
4.02	674,164	0		4.02
4.03	212,101	0		4.03
4.04	0	0		4.04
5.00	1,070,640			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	HOME OFFICE		6.00
7.00	HOSPITAL		7.00
8.00	HOSPITAL		8.00
9.00	HOME HEALTH		9.00
10.00	HOSPITAL		10.00
100.00			100.00

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet A-8-2 | Date/Time Prepared: 3/26/2021 8:45 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	263,412	263,412	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	224,850	224,850	0	0	0	2.00
3.00	50.00	OPERATING ROOM	33,704	33,704	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	146,616	146,156	460	0	0	4.00
5.00	91.00	EMERGENCY	2,671,819	1,815,964	855,855	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			3,340,401	2,484,086	856,315		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	263,412		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	224,850		2.00
3.00	50.00	OPERATING ROOM	0	0	0	33,704		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	146,156		4.00
5.00	91.00	EMERGENCY	0	0	0	1,815,964		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,484,086		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part I Date/Time Prepared: 3/26/2021 8:45 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,149,755	2,149,755				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,897,911		1,897,911			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,460,201	2,686	0	5,462,887		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,345,934	230,190	1,039,757	864,135	8,480,016	5.00
7.00	00700	OPERATION OF PLANT	1,591,843	652,394	40,893	293,194	2,578,324	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	162,153	5,853	0	7,421	175,427	8.00
9.00	00900	HOUSEKEEPING	474,147	42,601	3,426	144,518	664,692	9.00
10.00	01000	DIETARY	234,470	47,134	2,727	49,289	333,620	10.00
11.00	01100	CAFETERIA	333,958	77,765	5,196	93,905	510,824	11.00
13.00	01300	NURSING ADMINISTRATION	644,405	28,706	3,295	231,831	908,237	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	202,688	42,011	0	42,395	287,094	14.00
15.00	01500	PHARMACY	578,411	29,218	7,161	188,373	803,163	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	428,662	27,122	1,149	157,946	614,879	16.00
17.00	01700	SOCIAL SERVICE	62,637	3,027	0	23,109	88,773	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,422,486	262,575	48,740	813,052	3,546,853	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	867,003	171,459	264,351	229,272	1,532,085	50.00
53.00	05300	ANESTHESIOLOGY	64,942	6,350	35,967	0	107,259	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,908,802	110,880	334,109	452,833	2,806,624	54.00
60.00	06000	LABORATORY	2,067,883	63,063	43,831	351,053	2,525,830	60.00
64.00	06400	INTRAVENOUS THERAPY	143,115	24,405	0	46,897	214,417	64.00
65.00	06500	RESPIRATORY THERAPY	548,589	35,506	8,793	186,873	779,761	65.00
66.00	06600	PHYSICAL THERAPY	1,107,465	66,680	6,591	393,645	1,574,381	66.00
67.00	06700	OCCUPATIONAL THERAPY	310,244	22,977	0	113,147	446,368	67.00
68.00	06800	SPEECH PATHOLOGY	157,637	2,996	0	56,263	216,896	68.00
69.00	06900	ELECTROCARDIOLOGY	147,605	24,980	4,736	52,305	229,626	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	101,833	0	0	0	101,833	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	290,930	0	0	0	290,930	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,229,781	0	0	0	1,229,781	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	278,208	30,414	0	61,247	369,869	76.00
76.01	03950	DIABETIC EDUCATION	2,403	0	0	888	3,291	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,714,003	116,531	47,189	609,296	3,487,019	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,930,104	2,127,523	1,897,911	5,462,887	34,907,872	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,284	0	0	9,284	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,756	12,948	0	0	14,704	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	34,931,860	2,149,755	1,897,911	5,462,887	34,931,860	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part I | Date/Time Prepared: 3/26/2021 8:45 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,480,016					5.00
7.00	00700	OPERATION OF PLANT	826,567	3,404,891				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	56,239	15,760	247,426			8.00
9.00	00900	HOUSEKEEPING	213,089	114,711	4,826	997,318		9.00
10.00	01000	DIETARY	106,953	126,918	6,039	644	574,174	10.00
11.00	01100	CAFETERIA	163,761	209,399	0	14,174	0	11.00
13.00	01300	NURSING ADMINISTRATION	291,165	77,296	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	92,037	113,123	771	0	0	14.00
15.00	01500	PHARMACY	257,480	78,676	0	9,986	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	197,120	73,032	0	322	0	16.00
17.00	01700	SOCIAL SERVICE	28,459	8,152	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,137,068	707,040	120,696	341,781	574,174	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	491,160	461,689	19,312	106,303	0	50.00
53.00	05300	ANESTHESIOLOGY	34,385	17,098	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	899,756	298,568	18,539	40,589	0	54.00
60.00	06000	LABORATORY	809,738	169,810	387	65,715	0	60.00
64.00	06400	INTRAVENOUS THERAPY	68,738	65,717	0	27,059	0	64.00
65.00	06500	RESPIRATORY THERAPY	249,978	95,607	0	12,241	0	65.00
66.00	06600	PHYSICAL THERAPY	504,720	179,550	16,508	21,905	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	143,098	61,871	0	7,409	0	67.00
68.00	06800	SPEECH PATHOLOGY	69,533	8,068	0	6,765	0	68.00
69.00	06900	ELECTROCARDIOLOGY	73,614	67,263	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,646	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	93,267	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	394,247	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	118,574	81,895	0	23,193	0	76.00
76.01	03950	DIABETIC EDUCATION	1,055	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,117,879	313,784	60,348	266,725	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,472,326	3,345,027	247,426	944,811	574,174	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,976	24,999	0	8,053	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,714	34,865	0	44,454	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,480,016	3,404,891	247,426	997,318	574,174	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part I | Date/Time Prepared: 3/26/2021 8:45 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	898,158					11.00
13.00	01300	NURSING ADMINISTRATION	45,175	1,321,873				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,223	0	507,248			14.00
15.00	01500	PHARMACY	29,361	0	2,771	1,181,437		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	54,048	0	1	0	939,402	16.00
17.00	01700	SOCIAL SERVICE	5,215	17,138	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	204,711	680,262	37,043	0	276,764	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,616	150,391	56,743	0	57,026	50.00
53.00	05300	ANESTHESIOLOGY	11,954	39,392	1,971	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,986	0	21,422	0	72,232	54.00
60.00	06000	LABORATORY	81,885	0	207,264	0	94,663	60.00
64.00	06400	INTRAVENOUS THERAPY	8,602	0	5,002	0	51,323	64.00
65.00	06500	RESPIRATORY THERAPY	43,076	0	0	0	25,471	65.00
66.00	06600	PHYSICAL THERAPY	70,371	0	5,880	0	10,265	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,373	0	417	0	3,422	67.00
68.00	06800	SPEECH PATHOLOGY	9,651	0	542	0	760	68.00
69.00	06900	ELECTROCARDIOLOGY	11,514	0	1,153	0	15,207	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	32,741	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	93,538	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,181,437	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	14,325	0	60	0	7,603	76.00
76.01	03950	DIABETIC EDUCATION	169	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	131,903	434,690	40,225	0	324,666	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	898,158	1,321,873	506,773	1,181,437	939,402	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	475	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	898,158	1,321,873	507,248	1,181,437	939,402	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part I | Date/Time Prepared: 3/26/2021 8:45 am

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	147,737					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	147,737	0	7,774,129	-163,547	7,610,582	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	2,920,325	1,368	2,921,693	50.00
53.00	05300	ANESTHESIOLOGY	0	0	212,059	0	212,059	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	4,256,716	0	4,256,716	54.00
60.00	06000	LABORATORY	0	0	3,955,292	0	3,955,292	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	440,858	162,179	603,037	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,206,134	0	1,206,134	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,383,580	0	2,383,580	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	679,958	0	679,958	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	312,215	0	312,215	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	398,377	0	398,377	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	167,220	0	167,220	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	477,735	0	477,735	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,805,465	0	2,805,465	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	615,519	0	615,519	76.00
76.01	03950	DIABETIC EDUCATION	0	0	4,515	0	4,515	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	6,177,239	0	6,177,239	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	147,737	0	34,787,336	0	34,787,336	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	45,312	0	45,312	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	99,212	0	99,212	192.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	147,737	0	34,931,860	0	34,931,860	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part II Date/Time Prepared: 3/26/2021 8:45 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,686	0	2,686	2,686	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	285	230,190	1,039,757	1,270,232	421	5.00
7.00	00700	OPERATION OF PLANT	0	652,394	40,893	693,287	144	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,853	0	5,853	4	8.00
9.00	00900	HOUSEKEEPING	0	42,601	3,426	46,027	71	9.00
10.00	01000	DIETARY	62,287	47,134	2,727	112,148	24	10.00
11.00	01100	CAFETERIA	0	77,765	5,196	82,961	46	11.00
13.00	01300	NURSING ADMINISTRATION	0	28,706	3,295	32,001	114	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,047	42,011	0	44,058	21	14.00
15.00	01500	PHARMACY	0	29,218	7,161	36,379	93	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27,122	1,149	28,271	78	16.00
17.00	01700	SOCIAL SERVICE	0	3,027	0	3,027	11	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,053	262,575	48,740	329,368	401	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	116	171,459	264,351	435,926	113	50.00
53.00	05300	ANESTHESIOLOGY	0	6,350	35,967	42,317	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	110,880	334,109	444,989	223	54.00
60.00	06000	LABORATORY	0	63,063	43,831	106,894	173	60.00
64.00	06400	INTRAVENOUS THERAPY	0	24,405	0	24,405	23	64.00
65.00	06500	RESPIRATORY THERAPY	2,873	35,506	8,793	47,172	92	65.00
66.00	06600	PHYSICAL THERAPY	0	66,680	6,591	73,271	194	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	22,977	0	22,977	56	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,996	0	2,996	28	68.00
69.00	06900	ELECTROCARDIOLOGY	0	24,980	4,736	29,716	26	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	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	30,414	0	30,414	30	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	116,531	47,189	163,720	300	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85,661	2,127,523	1,897,911	4,111,095	2,686	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,284	0	9,284	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,948	0	12,948	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	85,661	2,149,755	1,897,911	4,133,327	2,686	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part II | Date/Time Prepared: 3/26/2021 8:45 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,270,653					5.00
7.00	00700	OPERATION OF PLANT	123,852	817,283				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,427	3,783	18,067			8.00
9.00	00900	HOUSEKEEPING	31,929	27,534	352	105,913		9.00
10.00	01000	DIETARY	16,026	30,464	441	68	159,171	10.00
11.00	01100	CAFETERIA	24,538	50,262	0	1,505	0	11.00
13.00	01300	NURSING ADMINISTRATION	43,628	18,554	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,791	27,153	56	0	0	14.00
15.00	01500	PHARMACY	38,581	18,885	0	1,060	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29,536	17,530	0	34	0	16.00
17.00	01700	SOCIAL SERVICE	4,264	1,957	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	170,389	169,712	8,814	36,298	159,171	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	73,595	110,820	1,410	11,289	0	50.00
53.00	05300	ANESTHESIOLOGY	5,152	4,104	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	134,819	71,666	1,354	4,310	0	54.00
60.00	06000	LABORATORY	121,331	40,760	28	6,979	0	60.00
64.00	06400	INTRAVENOUS THERAPY	10,300	15,774	0	2,874	0	64.00
65.00	06500	RESPIRATORY THERAPY	37,457	22,949	0	1,300	0	65.00
66.00	06600	PHYSICAL THERAPY	75,627	43,098	1,205	2,326	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,442	14,851	0	787	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,419	1,937	0	718	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,030	16,145	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,892	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,975	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,074	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	17,767	19,657	0	2,463	0	76.00
76.01	03950	DIABETIC EDUCATION	158	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	167,502	75,318	4,407	28,326	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,269,501	802,913	18,067	100,337	159,171	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	446	6,001	0	855	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	706	8,369	0	4,721	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,270,653	817,283	18,067	105,913	159,171	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part II | Date/Time Prepared: 3/26/2021 8:45 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	159,312					11.00
13.00	01300	NURSING ADMINISTRATION	8,013	102,310				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,523	0	87,602			14.00
15.00	01500	PHARMACY	5,208	0	479	100,685		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,587	0	0	0	85,036	16.00
17.00	01700	SOCIAL SERVICE	925	1,326	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,312	52,651	6,397	0	25,053	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,091	11,640	9,800	0	5,162	50.00
53.00	05300	ANESTHESIOLOGY	2,120	3,049	340	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,558	0	3,700	0	6,539	54.00
60.00	06000	LABORATORY	14,524	0	35,794	0	8,569	60.00
64.00	06400	INTRAVENOUS THERAPY	1,526	0	864	0	4,646	64.00
65.00	06500	RESPIRATORY THERAPY	7,641	0	0	0	2,306	65.00
66.00	06600	PHYSICAL THERAPY	12,482	0	1,016	0	929	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,081	0	72	0	310	67.00
68.00	06800	SPEECH PATHOLOGY	1,712	0	94	0	69	68.00
69.00	06900	ELECTROCARDIOLOGY	2,042	0	199	0	1,377	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	5,654	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	16,154	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100,685	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,541	0	10	0	688	76.00
76.01	03950	DIABETIC EDUCATION	30	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	23,396	33,644	6,947	0	29,388	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	159,312	102,310	87,520	100,685	85,036	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	82	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	159,312	102,310	87,602	100,685	85,036	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B Part II | Date/Time Prepared: 3/26/2021 8:45 am

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	11,510					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,510		1,006,076	0	1,006,076	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		667,846	0	667,846	50.00
53.00	05300	ANESTHESIOLOGY	0		57,082	0	57,082	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		685,158	0	685,158	54.00
60.00	06000	LABORATORY	0		335,052	0	335,052	60.00
64.00	06400	INTRAVENOUS THERAPY	0		60,412	0	60,412	64.00
65.00	06500	RESPIRATORY THERAPY	0		118,917	0	118,917	65.00
66.00	06600	PHYSICAL THERAPY	0		210,148	0	210,148	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		63,576	0	63,576	67.00
68.00	06800	SPEECH PATHOLOGY	0		17,973	0	17,973	68.00
69.00	06900	ELECTROCARDIOLOGY	0		60,535	0	60,535	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		10,546	0	10,546	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		30,129	0	30,129	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		159,759	0	159,759	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		73,570	0	73,570	76.00
76.01	03950	DIABETIC EDUCATION	0		188	0	188	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0		532,948	0	532,948	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,510	0	4,089,915	0	4,089,915	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		16,586	0	16,586	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		26,826	0	26,826	192.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,510	0	4,133,327	0	4,133,327	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B-1 | Date/Time Prepared: 3/26/2021 8:45 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	138,470					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,880,148				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	173	0	14,787,628			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,827	1,030,027	2,339,148	-8,480,016	26,451,844	5.00
7.00	00700	OPERATION OF PLANT	42,022	40,510	793,655	0	2,578,324	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	377	0	20,089	0	175,427	8.00
9.00	00900	HOUSEKEEPING	2,744	3,394	391,199	0	664,692	9.00
10.00	01000	DIETARY	3,036	2,701	133,422	0	333,620	10.00
11.00	01100	CAFETERIA	5,009	5,147	254,194	0	510,824	11.00
13.00	01300	NURSING ADMINISTRATION	1,849	3,264	627,550	0	908,237	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,706	0	114,761	0	287,094	14.00
15.00	01500	PHARMACY	1,882	7,094	509,911	0	803,163	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,747	1,138	427,549	0	614,879	16.00
17.00	01700	SOCIAL SERVICE	195	0	62,555	0	88,773	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,913	48,284	2,200,869	0	3,546,853	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,044	261,877	620,622	0	1,532,085	50.00
53.00	05300	ANESTHESIOLOGY	409	35,630	0	0	107,259	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,142	330,982	1,225,784	0	2,806,624	54.00
60.00	06000	LABORATORY	4,062	43,421	950,275	0	2,525,830	60.00
64.00	06400	INTRAVENOUS THERAPY	1,572	0	126,947	0	214,417	64.00
65.00	06500	RESPIRATORY THERAPY	2,287	8,711	505,852	0	779,761	65.00
66.00	06600	PHYSICAL THERAPY	4,295	6,529	1,065,568	0	1,574,381	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,480	0	306,280	0	446,368	67.00
68.00	06800	SPEECH PATHOLOGY	193	0	152,300	0	216,896	68.00
69.00	06900	ELECTROCARDIOLOGY	1,609	4,692	141,587	0	229,626	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	101,833	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	290,930	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,229,781	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,959	0	165,791	0	369,869	76.00
76.01	03950	DIABETIC EDUCATION	0	0	2,403	0	3,291	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,506	46,747	1,649,317	0	3,487,019	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	137,038	1,880,148	14,787,628	-8,480,016	26,427,856	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	598	0	0	0	9,284	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	834	0	0	0	14,704	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,149,755	1,897,911	5,462,887		8,480,016	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.525060	1.009448	0.369423		0.320583	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			2,686		1,270,653	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000182		0.048036	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B-1 | Date/Time Prepared: 3/26/2021 8:45 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	81,448					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	377	205,070				8.00
9.00	00900	HOUSEKEEPING	2,744	4,000	3,096			9.00
10.00	01000	DIETARY	3,036	5,005	2	20,535		10.00
11.00	01100	CAFETERIA	5,009	0	44	0	26,522	11.00
13.00	01300	NURSING ADMINISTRATION	1,849	0	0	0	1,334	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,706	639	0	0	420	14.00
15.00	01500	PHARMACY	1,882	0	31	0	867	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,747	0	1	0	1,596	16.00
17.00	01700	SOCIAL SERVICE	195	0	0	0	154	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,913	100,035	1,061	20,535	6,045	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,044	16,006	330	0	1,347	50.00
53.00	05300	ANESTHESIOLOGY	409	0	0	0	353	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,142	15,365	126	0	2,923	54.00
60.00	06000	LABORATORY	4,062	321	204	0	2,418	60.00
64.00	06400	INTRAVENOUS THERAPY	1,572	0	84	0	254	64.00
65.00	06500	RESPIRATORY THERAPY	2,287	0	38	0	1,272	65.00
66.00	06600	PHYSICAL THERAPY	4,295	13,682	68	0	2,078	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,480	0	23	0	513	67.00
68.00	06800	SPEECH PATHOLOGY	193	0	21	0	285	68.00
69.00	06900	ELECTROCARDIOLOGY	1,609	0	0	0	340	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	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,959	0	72	0	423	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	5	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,506	50,017	828	0	3,895	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	80,016	205,070	2,933	20,535	26,522	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	598	0	25	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	834	0	138	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,404,891	247,426	997,318	574,174	898,158	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	41.804476	1.206544	322.131137	27.960750	33.864641	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	817,283	18,067	105,913	159,171	159,312	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.034415	0.088102	34.209625	7.751205	6.006787	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B-1 | Date/Time Prepared: 3/26/2021 8:45 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	157,114					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,577,681				14.00
15.00	01500	PHARMACY	0	8,620	1,229,781			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2	0	2,471		16.00
17.00	01700	SOCIAL SERVICE	2,037	0	0	0	2,037	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	80,854	115,214	0	728	2,037	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,875	176,486	0	150	0	50.00
53.00	05300	ANESTHESIOLOGY	4,682	6,130	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	66,629	0	190	0	54.00
60.00	06000	LABORATORY	0	644,647	0	249	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	15,557	0	135	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	67	0	65.00
66.00	06600	PHYSICAL THERAPY	0	18,289	0	27	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,297	0	9	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,687	0	2	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,587	0	40	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	101,833	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	290,930	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,229,781	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	186	0	20	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	51,666	125,110	0	854	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	157,114	1,576,204	1,229,781	2,471	2,037	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,477	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,321,873	507,248	1,181,437	939,402	147,737	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.413464	0.321515	0.960689	380.170781	72.526755	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	102,310	87,602	100,685	85,036	11,510	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.651183	0.055526	0.081872	34.413598	5.650466	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B-1 | Date/Time Prepared: 3/26/2021 8:45 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	76.00
76.01	03950	DIABETIC EDUCATION	0	76.01
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet B-2 | Date/Time Prepared: 3/26/2021 8:45 am

		Description	Worksheet CODE	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		IV THERAPY & ANCILLARIES	1	30.00	-163,547	7.00
8.00		ANCILLARIES	1	50.00	1,368	8.00
9.00		IV THERAPY	1	64.00	162,179	9.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part I Date/Time Prepared: 3/26/2021 8:45 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,610,582		7,610,582	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,921,693		2,921,693	0	0	50.00
53.00	05300	ANESTHESIOLOGY	212,059		212,059	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,256,716		4,256,716	0	0	54.00
60.00	06000	LABORATORY	3,955,292		3,955,292	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	603,037		603,037	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,206,134	0	1,206,134	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,383,580	0	2,383,580	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	679,958	0	679,958	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	312,215	0	312,215	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	398,377		398,377	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	167,220		167,220	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	477,735		477,735	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,805,465		2,805,465	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	615,519		615,519	0	0	76.00
76.01	03950	DIABETIC EDUCATION	4,515		4,515	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,177,239		6,177,239	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	339,379		339,379		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	35,126,715	0	35,126,715	0	0	200.00
201.00		Less Observation Beds	339,379		339,379		0	201.00
202.00		Total (see instructions)	34,787,336	0	34,787,336	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part I Date/Time Prepared: 3/26/2021 8:45 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,845,888		5,845,888			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	223,250	4,070,327	4,293,577	0.680480	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	38,825	550,041	588,866	0.360114	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,766,281	33,731,045	35,497,326	0.119917	0.000000	54.00
60.00	06000	LABORATORY	2,071,763	11,143,399	13,215,162	0.299300	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	16,509	1,437,957	1,454,466	0.414611	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,195,826	2,080,742	3,276,568	0.368109	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	703,141	3,351,419	4,054,560	0.587876	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	762,542	642,698	1,405,240	0.483873	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	270,488	531,812	802,300	0.389150	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	111,980	1,839,915	1,951,895	0.204098	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	454,727	502,896	957,623	0.174620	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	449,436	1,499,182	1,948,618	0.245166	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,840,938	7,285,348	9,126,286	0.307405	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	441,922	441,922	1.392823	0.000000	76.00
76.01	03950	DIABETIC EDUCATION	2,880	11,127	14,007	0.322339	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	219,470	14,354,245	14,573,715	0.423862	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	963,287	963,287	0.352313	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	15,973,944	84,437,362	100,411,306			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,973,944	84,437,362	100,411,306			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet C Part I Date/Time Prepared: 3/26/2021 8:45 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
76.01	03950	DIABETIC EDUCATION	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part II Date/Time Prepared: 3/26/2021 8:45 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	667,846	4,293,577	0.155545	95,814	14,903	50.00
53.00	05300	ANESTHESIOLOGY	57,082	588,866	0.096935	15,438	1,496	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	685,158	35,497,326	0.019302	1,027,537	19,834	54.00
60.00	06000	LABORATORY	335,052	13,215,162	0.025354	924,493	23,440	60.00
64.00	06400	INTRAVENOUS THERAPY	60,412	1,454,466	0.041536	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	118,917	3,276,568	0.036293	507,163	18,406	65.00
66.00	06600	PHYSICAL THERAPY	210,148	4,054,560	0.051830	81,227	4,210	66.00
67.00	06700	OCCUPATIONAL THERAPY	63,576	1,405,240	0.045242	75,464	3,414	67.00
68.00	06800	SPEECH PATHOLOGY	17,973	802,300	0.022402	57,437	1,287	68.00
69.00	06900	ELECTROCARDIOLOGY	60,535	1,951,895	0.031013	57,543	1,785	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,546	957,623	0.011013	185,868	2,047	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,129	1,948,618	0.015462	159,231	2,462	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	159,759	9,126,286	0.017505	719,106	12,588	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	73,570	441,922	0.166477	0	0	76.00
76.01	03950	DIABETIC EDUCATION	188	14,007	0.013422	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	532,948	14,573,715	0.036569	2,353	86	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	44,864	963,287	0.046574	0	0	92.00
200.00		Total (lines 50 through 199)	3,128,703	94,565,418		3,908,674	105,958	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part IV | Date/Time Prepared: 3/26/2021 8:45 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	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	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part IV | Date/Time Prepared: 3/26/2021 8:45 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	4,293,577	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	588,866	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	35,497,326	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	13,215,162	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,454,466	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,276,568	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,054,560	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,405,240	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	802,300	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,951,895	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	957,623	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,948,618	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,126,286	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	441,922	0.000000	76.00
76.01	03950	DIABETIC EDUCATION	0	0	0	14,007	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	14,573,715	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	963,287	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	94,565,418		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part IV | Date/Time Prepared: 3/26/2021 8:45 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	95,814	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	15,438	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,027,537	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	924,493	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	507,163	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	81,227	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	75,464	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	57,437	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	57,543	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	185,868	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	159,231	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	719,106	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	2,353	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,908,674	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part V Date/Time Prepared: 3/26/2021 8:45 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.680480	0	1,745,128	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.360114	0	203,175	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119917	0	12,289,755	0	0	54.00
60.00	06000	LABORATORY	0.299300	0	3,961,976	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.414611	0	716,323	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.368109	0	832,505	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.587876	0	1,186,156	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.483873	0	223,511	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.389150	0	70,134	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.204098	0	803,777	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.174620	0	181,894	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.245166	0	956,842	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.307405	0	4,676,860	3,422	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.392823	0	335,994	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.322339	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.423862	0	3,809,992	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.352313	0	519,287	0	0	92.00
200.00		Subtotal (see instructions)		0	32,513,309	3,422	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	32,513,309	3,422	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D Part V Date/Time Prepared: 3/26/2021 8:45 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,187,525	0	50.00
53.00	05300	ANESTHESIOLOGY	73,166	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,473,751	0	54.00
60.00	06000	LABORATORY	1,185,819	0	60.00
64.00	06400	INTRAVENOUS THERAPY	296,995	0	64.00
65.00	06500	RESPIRATORY THERAPY	306,453	0	65.00
66.00	06600	PHYSICAL THERAPY	697,313	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	108,151	0	67.00
68.00	06800	SPEECH PATHOLOGY	27,293	0	68.00
69.00	06900	ELECTROCARDIOLOGY	164,049	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	31,762	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	234,585	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,437,690	1,052	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	467,980	0	76.00
76.01	03950	DIABETIC EDUCATION	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	1,614,911	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	182,952	0	92.00
200.00		Subtotal (see instructions)	9,490,395	1,052	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	9,490,395	1,052	202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1339	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 3/26/2021 8:45 am
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,949	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,127	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,910	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	683	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	2,047	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	23	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	69	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,365	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	502	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	1,533	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	157.19	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	157.19	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,610,582	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	3,615	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	10,846	25.00
26.00	Total swing-bed cost (see instructions)	4,284,045	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,326,537	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,326,537	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,563.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,134,792	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,134,792	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-1 | Date/Time Prepared: 3/26/2021 8:45 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,069,280	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,204,072	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	785,103	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	2,397,535	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	3,182,638	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	217	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,563.96	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	339,379	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-1 | Date/Time Prepared: 3/26/2021 8:45 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,006,076	7,610,582	0.132194	339,379	44,864	90.00
91.00	Nursing School cost	0	7,610,582	0.000000	339,379	0	91.00
92.00	Allied health cost	0	7,610,582	0.000000	339,379	0	92.00
93.00	All other Medical Education	0	7,610,582	0.000000	339,379	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-3 | Date/Time Prepared: 3/26/2021 8:45 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,311,161		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.680480	95,814	65,200	50.00
53.00	05300	ANESTHESIOLOGY	0.360114	15,438	5,559	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119917	1,027,537	123,219	54.00
60.00	06000	LABORATORY	0.299300	924,493	276,701	60.00
64.00	06400	INTRAVENOUS THERAPY	0.414611	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.368109	507,163	186,691	65.00
66.00	06600	PHYSICAL THERAPY	0.587876	81,227	47,751	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.483873	75,464	36,515	67.00
68.00	06800	SPEECH PATHOLOGY	0.389150	57,437	22,352	68.00
69.00	06900	ELECTROCARDIOLOGY	0.204098	57,543	11,744	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.174620	185,868	32,456	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.245166	159,231	39,038	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.307405	719,106	221,057	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.392823	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.322339	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.423862	2,353	997	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.352313	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,908,674	1,069,280	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		3,908,674		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1339 | Component CCN: 14-Z339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet D-3 | Date/Time Prepared: 3/26/2021 8:45 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.680480	8,722	5,935	50.00
53.00	05300	ANESTHESIOLOGY	0.360114	498	179	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119917	222,413	26,671	54.00
60.00	06000	LABORATORY	0.299300	510,523	152,800	60.00
64.00	06400	INTRAVENOUS THERAPY	0.414611	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.368109	331,093	121,878	65.00
66.00	06600	PHYSICAL THERAPY	0.587876	399,154	234,653	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.483873	453,630	219,499	67.00
68.00	06800	SPEECH PATHOLOGY	0.389150	136,022	52,933	68.00
69.00	06900	ELECTROCARDIOLOGY	0.204098	6,842	1,396	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.174620	120,526	21,046	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.245166	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.307405	509,494	156,621	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.392823	0	0	76.00
76.01	03950	DIABETIC EDUCATION	0.322339	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.423862	3,321	1,408	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.352313	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,702,238	995,019	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,702,238		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1339	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part B Date/Time Prepared: 3/26/2021 8:45 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,491,447	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	9,491,447	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	9,586,361	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	53,009	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,626,661	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,906,691	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,906,691	30.00
31.00	Primary payer payments	188	31.00
32.00	Subtotal (line 30 minus line 31)	3,906,503	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	807,644	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	524,969	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	641,197	36.00
37.00	Subtotal (see instructions)	4,431,472	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,431,472	40.00
40.01	Sequestration adjustment (see instructions)	51,405	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,585,513	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	794,554	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet E-1 Part I | Date/Time Prepared: 3/26/2021 8:45 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,085,702		4,120,146	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	09/07/2020	159,358		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	09/07/2020	534,633	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		159,358		-534,633	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,245,060		3,585,513	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		794,554	6.01
6.02	SETTLEMENT TO PROGRAM		310,501		0	6.02
7.00	Total Medicare program liability (see instructions)		2,934,559		4,380,067	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1339 | Component CCN: 14-Z339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet E-1 Part I | Date/Time Prepared: 3/26/2021 8:45 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,988,365		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	09/07/2020	124,294		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		124,294		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,112,659		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		5,623		0	6.02
7.00	Total Medicare program liability (see instructions)		4,107,036		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1339	Period: From 10/01/2019 To 09/30/2020	Worksheet E-1 Part II Date/Time Prepared: 3/26/2021 8:45 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-1339 | Component CCN: 14-Z339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet E-2 | Date/Time Prepared: 3/26/2021 8:45 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	3,214,464	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	1,004,969	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	2,035	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	4,219,433	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	4,219,433	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	4,219,433	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	64,196	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	4,155,237	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	4,155,237	0	19.00
19.01	Sequestration adjustment (see instructions)	48,201	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	4,112,659	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-5,623	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1339	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part V Date/Time Prepared: 3/26/2021 8:45 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,204,072	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,204,072	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,236,113	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,236,113	19.00
20.00	Deductibles (exclude professional component)	318,296	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,917,817	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,917,817	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	78,741	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	51,182	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	68,055	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,968,999	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	2,968,999	30.00
30.01	Sequestration adjustment (see instructions)	34,440	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	3,245,060	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-310,501	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet G | Date/Time Prepared: 3/26/2021 8:45 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,638,102	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	8,787,057	0	0	0	3.00
4.00	Accounts receivable	0	0	0	0	4.00
5.00	Other receivable	260,676	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,836,715	0	0	0	6.00
7.00	Inventory	358,033	0	0	0	7.00
8.00	Prepaid expenses	381,122	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	352,018	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	9,940,293	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,058,695	0	0	0	12.00
13.00	Land improvements	4,369,208	0	0	0	13.00
14.00	Accumulated depreciation	-2,055,664	0	0	0	14.00
15.00	Buildings	16,767,579	0	0	0	15.00
16.00	Accumulated depreciation	-7,042,075	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	24,510,710	0	0	0	23.00
24.00	Accumulated depreciation	-24,709,820	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	46,212,137	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	59,110,770	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	39,195,283	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	4,030,856	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	43,226,139	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	112,277,202	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,056,151	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,493,150	0	0	0	38.00
39.00	Payroll taxes payable	1,791	0	0	0	39.00
40.00	Notes and loans payable (short term)	483,168	0	0	0	40.00
41.00	Deferred income	9,695,266	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	919,374	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	16,648,900	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	15,069,475	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	5,579	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15,075,054	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	31,723,954	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	80,553,248				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	80,553,248	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	112,277,202	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet G-1 | Date/Time Prepared: 3/26/2021 8:45 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		70,796,847		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,698,131				2.00
3.00	Total (sum of line 1 and line 2)		80,494,978		0		3.00
4.00	INCREASE IN RESRICTED ASSETS	58,269		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		58,269		0		10.00
11.00	Subtotal (line 3 plus line 10)		80,553,247		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		80,553,247		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	INCREASE IN RESRICTED ASSETS		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet G-2 Parts I & II Date/Time Prepared: 3/26/2021 8:45 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,579,468		2,579,468	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	3,177,426		3,177,426	5.00
6.00	Swing bed - NF	107,078		107,078	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,863,972		5,863,972	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	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,863,972		5,863,972	17.00
18.00	Ancillary services	9,945,603	70,723,497	80,669,100	18.00
19.00	Outpatient services	222,087	15,485,003	15,707,090	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	345,587	8,763,801	9,109,388	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	16,377,249	94,972,301	111,349,550	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		39,263,435		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		39,263,435		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1339 | Period: From 10/01/2019 To 09/30/2020 | Worksheet G-3 | Date/Time Prepared: 3/26/2021 8:45 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	111,349,550	1.00
2.00	Less contractual allowances and discounts on patients' accounts	66,146,232	2.00
3.00	Net patient revenues (line 1 minus line 2)	45,203,318	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	39,263,435	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,939,883	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	266,231	6.00
7.00	Income from investments	155,491	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	112,751	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	5,885	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	12,875	22.00
23.00	Governmental appropriations	0	23.00
24.00	CHANGE IN INTEREST IN FOUNDATION	499,562	24.00
24.01	UNREALIZED GAINS ON INVESTMENTS	90,451	24.01
24.02	MISCELLANEOUS INCOME	8,233	24.02
24.50	COVID-19 PHE Funding	2,606,769	24.50
25.00	Total other income (sum of lines 6-24)	3,758,248	25.00
26.00	Total (line 5 plus line 25)	9,698,131	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,698,131	29.00