

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).

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 26-4012	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 5/24/2021 10:30 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 5/24/2021	Time: 10:30 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CENTERPOINTE HOSPITAL (26-4012) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-225,733	-133,451	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	-225,733	-133,451	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 26-4012		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 5/24/2021 10:30 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 4801 WELDON SPRINGS PARKWAY			PO Box:				1.00	
2.00	City: ST. CHARLES			State: MO		Zip Code: 63304		County: ST. CHARLES	
		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			CENTERPOINTE HOSPITAL	264012	41180	4	12/31/1980	N
4.00	Subprovider - IPF							P	O
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2020	12/31/2020	
21.00	Type of Control (see instructions)						4		
							1.00	2.00	
							2.00	3.00	
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		
				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
5/24/2021 10:30 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.	1						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.	1						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.							57.00	
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							58.00	
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N						59.00	
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N						60.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
5/24/2021 10:30 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		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 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

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From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
5/24/2021 10:30 am

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
			1.00	2.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00		
					1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				Y		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	

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N			80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N			81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N			85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	N			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N			87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00

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		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N					110.00
						1.00	
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	
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.	Y		E		98	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:	166,383		0		0	118.01
						1.00	
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.	N					121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N					122.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N					125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-4012		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 5/24/2021 10:30 am	
		1.00		2.00			
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			N		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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-4012	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 5/24/2021 10:30 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-4012		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part II Date/Time Prepared: 5/24/2021 10:30 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)	N					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	04/16/2021	Y	04/16/2021		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: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
5/24/2021 10:30 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.		N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA		RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314.231.5544		PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
5/24/2021 10:30 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.	MANAGING 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: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
5/24/2021 10:30 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	78	32,180	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		78	32,180	0.00	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)		78	32,180	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	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	99.00				0	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)		78			0	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: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
5/24/2021 10:30 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)	6,020	551	25,703		1.00
2.00	HMO and other (see instructions)	0	1,464			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	6,020	551	25,703		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)	6,020	551	25,703	0.00	270.67
15.00	CAH visits	0	0	0		14.00
16.00	SUBPROVIDER - IPF					15.00
17.00	SUBPROVIDER - IRF					16.00
18.00	SUBPROVIDER					17.00
19.00	SKILLED NURSING FACILITY					18.00
20.00	NURSING FACILITY					19.00
21.00	OTHER LONG TERM CARE					20.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	21.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					22.00
24.00	HOSPICE					23.00
24.10	HOSPICE (non-distinct part)			0		24.00
25.00	CMHC - CMHC	0	0	0	0.00	24.10
26.00	RURAL HEALTH CLINIC					25.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.00
27.00	Total (sum of lines 14-26)				0.00	26.25
28.00	Observation Bed Days		0	0		27.00
29.00	Ambulance Trips	0				28.00
30.00	Employee discount days (see instruction)			0		29.00
31.00	Employee discount days - IRF			0		30.00
32.00	Labor & delivery days (see instructions)	0	0	0		31.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.00
33.00	LTCH non-covered days	0				32.01
33.01	LTCH site neutral days and discharges	0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
5/24/2021 10:30 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	408	57	2,659	1.00
2.00 HMO and other (see instructions)			0	187		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	408	57	2,659	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	0.00					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	0.00					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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-4012

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

Worksheet A

Date/Time Prepared:
5/24/2021 10:30 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		302,477	302,477	2,696,720	2,999,197	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		289,127	289,127	346,847	635,974	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	152,888	3,927,971	4,080,859	412	4,081,271	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,675,216	4,843,685	9,518,901	-2,807,322	6,711,579	5.00
6.00	00600	MAINTENANCE & REPAIRS	277,450	599,594	877,044	1,305	878,349	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	101,860	101,860	0	101,860	8.00
9.00	00900	HOUSEKEEPING	0	430,163	430,163	611	430,774	9.00
10.00	01000	DIETARY	273,610	633,802	907,412	5,436	912,848	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	807,756	145,474	953,230	-4,288	948,942	13.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	193,541	173,149	366,690	-13,701	352,989	16.00
17.00	01700	SOCIAL SERVICE	486,326	1,685	488,011	86,935	574,946	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,887,213	2,773,943	8,661,156	182,634	8,843,790	30.00
ANCILLARY SERVICE COST CENTERS								
69.00	06900	ELECTROCARDIOLOGY	234,483	170,636	405,119	5,218	410,337	69.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	845,500	473,739	1,319,239	-274,343	1,044,896	90.00
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,833,983	14,867,305	28,701,288	226,464	28,927,752	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	COMMUNITY RELATIONS	0	0	0	0	0	191.01
191.02	19102	RETAIL PHARMACY	0	0	0	0	0	191.02
191.03	19103	NON HOSPITAL O/P	1,043,964	354,386	1,398,350	-269,260	1,129,090	191.03
191.04	19104	CHEMICAL DEPENDENCY/S.A.F.E.	981,415	69,459	1,050,874	42,796	1,093,670	191.04
200.00		TOTAL (SUM OF LINES 118 through 199)	15,859,362	15,291,150	31,150,512	0	31,150,512	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-4012

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

Worksheet A

Date/Time Prepared:
5/24/2021 10:30 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	2,999,197	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	635,974	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-163,911	3,917,360	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	507,878	7,219,457	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	878,349	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	101,860	8.00
9.00	00900	HOUSEKEEPING	0	430,774	9.00
10.00	01000	DIETARY	-21,084	891,764	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	948,942	13.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,921	350,068	16.00
17.00	01700	SOCIAL SERVICE	0	574,946	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-530,518	8,313,272	30.00
ANCILLARY SERVICE COST CENTERS					
69.00	06900	ELECTROCARDIOLOGY	-6,912	403,425	69.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-14,345	1,030,551	90.00
OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-231,813	28,695,939	118.00
NONREIMBURSABLE COST CENTERS					
191.00	19100	RESEARCH	0	0	191.00
191.01	19101	COMMUNITY RELATIONS	0	0	191.01
191.02	19102	RETAIL PHARMACY	0	0	191.02
191.03	19103	NON HOSPITAL O/P	0	1,129,090	191.03
191.04	19104	CHEMICAL DEPENDENCY/S.A.F.E.	0	1,093,670	191.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-231,813	30,918,699	200.00

RECLASSIFICATIONS

Provider CCN: 26-4012

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

Worksheet A-6

Date/Time Prepared:
5/24/2021 10:30 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS POSTAGE & TELEPHONE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	29,318		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
	0		0	29,318		
	B - RECLASS SHORT 7 LONG TERM LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,400,245		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	46,892		2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	1,108		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
	0		0	2,448,245		
	G - RECLASS RADIOLOGY EXPENSE					
1.00	CHEMICAL DEPENDENCY/S.A.F.E.	191.04	0	10,558		1.00
	0		0	10,558		
	H - RECLASS LABORATORY EXPENSE					
1.00	CHEMICAL DEPENDENCY/S.A.F.E.	191.04	0	17,937		1.00
	0		0	17,937		
	I - TO RECLASS INSURANCE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	138,826		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	144,653		2.00
	0		0	283,479		
	K - TO RECLASS PROPERTY TAX EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	157,649		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	155,302		2.00
	0		0	312,951		
	L - TO RECLASS COVID-19 EXPENSE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,033	0		1.00
2.00	MAINTENANCE & REPAIRS	6.00	303	0		2.00
3.00	HOUSEKEEPING	9.00	611	0		3.00
4.00	DIETARY	10.00	5,436	0		4.00
5.00	NURSING ADMINISTRATION	13.00	4,581	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	5,333	0		6.00
7.00	SOCIAL SERVICE	17.00	86,935	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	208,509	2,778		8.00
9.00	ELECTROCARDIOLOGY	69.00	6,158	0		9.00
10.00	CLINIC	90.00	11,230	0		10.00
11.00	NON HOSPITAL O/P	191.03	20,498	0		11.00
12.00	CHEMICAL DEPENDENCY/S.A.F.E.	191.04	14,301	0		12.00
	TOTALS		364,928	2,778		
500.00	Grand Total: Increases		364,928	3,105,266		500.00

RECLASSIFICATIONS

Provider CCN: 26-4012

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

Worksheet A-6

Date/Time Prepared:
5/24/2021 10:30 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS POSTAGE & TELEPHONE EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	215	0		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	106	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	150	0		3.00
4.00	CLINIC	90.00	0	12,072	0		4.00
5.00	NON HOSPITAL O/P	191.03	0	16,775	0		5.00
			0	29,318			
	B - RECLASS SHORT 7 LONG TERM LEASES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	406	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,872,504	10		2.00
3.00	NURSING ADMINISTRATION	13.00	0	8,869	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	18,884	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	158	0		5.00
6.00	ELECTROCARDIOLOGY	69.00	0	940	0		6.00
7.00	CLINIC	90.00	0	273,501	0		7.00
8.00	NON HOSPITAL O/P	191.03	0	272,983	0		8.00
9.00	NON HOSPITAL O/P		0		0		9.00
			0	2,448,245			
	G - RECLASS RADIOLOGY EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	10,558	0		1.00
			0	10,558			
	H - RECLASS LABORATORY EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	17,937	0		1.00
			0	17,937			
	I - TO RECLASS INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	283,479	12		1.00
2.00		0.00	0	0	12		2.00
			0	283,479			
	K - TO RECLASS PROPERTY TAX EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	312,951	13		1.00
2.00		0.00	0	0	13		2.00
			0	312,951			
	L - TO RECLASS COVID-19 EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	364,928	2,778	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
	TOTALS		364,928	2,778			
500.00	Grand Total: Decreases		364,928	3,105,266			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
5/24/2021 10:30 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	2,849,460	87,233	0	87,233	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	2,756,845	136,111	0	136,111	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	5,606,305	223,344	0	223,344	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	5,606,305	223,344	0	223,344	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	2,936,693	0				
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	2,892,956	0				
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	5,829,649	0				
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	5,829,649	0				

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
5/24/2021 10:30 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	302,477	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	289,127	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	591,604	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		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	302,477				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	289,127				2.00
3.00	Total (sum of lines 1-2)	0	591,604				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
5/24/2021 10:30 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	2,936,693	0	2,936,693	0.503751	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,892,956	0	2,892,956	0.496249	0	2.00
3.00	Total (sum of lines 1-2)	5,829,649	0	5,829,649	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	302,477	2,400,245	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	289,127	46,892	2.00
3.00	Total (sum of lines 1-2)	0	0	0	591,604	2,447,137	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	138,826	157,649	0	2,999,197	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	144,653	155,302	0	635,974	2.00
3.00	Total (sum of lines 1-2)	0	283,479	312,951	0	3,635,171	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-4012

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

Worksheet A-8

Date/Time Prepared:
5/24/2021 10:30 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0DIETARY	10.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			0	0.00	0	7.00
8.00	Television and radio service (chapter 21)			0	0.00	0	8.00
9.00	Parking lot (chapter 21)			0	0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-918,569			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		0		0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-17,903	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others	B	-38,400	ADMINISTRATIVE & GENERAL	5.00	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	-2,921	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	B	-3,181	DIETARY	10.00	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*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-4012

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

Worksheet A-8

Date/Time Prepared:
5/24/2021 10:30 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	DONATIONS & GIFTS	B	-760	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	OTHER INCOME	B	-26,422	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	FRA	A	1,804,728	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	LOBBYING EXPENSE	A	-14,594	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	COMMUNITY RELATIONS EXPENSES	A	-298,993	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	COMMUNITY RELATIONS SALARIES	A	-486,508	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	COMMUNITY RELATIONS BENEFITS	A	-70,865	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	ALZMER ASSOC	A	-5,272	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	PHYSICIAN BENEFITS	A	-93,046	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	NON-PHYSICIAN	A	-49,872	ADULTS & PEDIATRICS	30.00	0	33.09
33.10	NON-PHYSICIAN	A	-9,235	ADMINISTRATIVE & GENERAL	5.00	0	33.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-231,813				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 26-4012

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

Worksheet A-8-2

Date/Time Prepared:
5/24/2021 10:30 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	416,666	416,666	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	495,898	478,898	17,000	211,500	150	2.00
3.00	69.00	ELECTROCARDIOLOGY	16,500	0	16,500	181,300	110	3.00
4.00	90.00	CLINIC	17,802	13,302	4,500	211,500	34	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			946,866	908,866	38,000		294	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	15,252	763	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	9,588	479	0	0	0	3.00
4.00	90.00	CLINIC	3,457	173	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			28,297	1,415	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	416,666		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	15,252	1,748	480,646		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	9,588	6,912	6,912		3.00
4.00	90.00	CLINIC	0	3,457	1,043	14,345		4.00
5.00	0.00		0	0	0	0		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	28,297	9,703	918,569		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
5/24/2021 10:30 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	2,999,197	2,999,197			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	635,974	635,974			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,917,360	22,676	4,808	3,944,844	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,219,457	582,723	123,565	1,046,611	8,972,356
6.00	00600	MAINTENANCE & REPAIRS	878,349	29,361	6,226	72,894	986,830
8.00	00800	LAUNDRY & LINEN SERVICE	101,860	18,671	3,959	0	124,490
9.00	00900	HOUSEKEEPING	430,774	33,985	7,206	0	471,965
10.00	01000	DIETARY	891,764	254,652	53,999	71,885	1,272,300
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	948,942	3,534	749	212,221	1,165,446
15.00	01500	PHARMACY	0	10,278	2,179	0	12,457
16.00	01600	MEDICAL RECORDS & LIBRARY	350,068	20,733	4,396	50,849	426,046
17.00	01700	SOCIAL SERVICE	574,946	6,008	1,274	127,772	710,000
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,313,272	1,006,625	213,455	1,546,744	11,080,096
ANCILLARY SERVICE COST CENTERS							
69.00	06900	ELECTROCARDIOLOGY	403,425	120,185	25,485	61,605	610,700
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,030,551	471,167	99,910	222,137	1,823,765
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,695,939	2,580,598	547,211	3,412,718	27,656,451
NONREIMBURSABLE COST CENTERS							
191.00	19100	RESEARCH	0	0	0	0	0
191.01	19101	COMMUNITY RELATIONS	0	0	0	0	0
191.02	19102	RETAIL PHARMACY	0	0	0	0	0
191.03	19103	NON HOSPITAL O/P	1,129,090	99,275	21,051	274,280	1,523,696
191.04	19104	CHEMICAL DEPENDENCY/S.A.F.E.	1,093,670	319,324	67,712	257,846	1,738,552
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	30,918,699	2,999,197	635,974	3,944,844	30,918,699

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
5/24/2021 10:30 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	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	8,972,356					5.00
6.00	00600	MAINTENANCE & REPAIRS	403,447	1,390,277				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	50,895	10,979	186,364			8.00
9.00	00900	HOUSEKEEPING	192,954	19,983	0	684,902		9.00
10.00	01000	DIETARY	520,156	149,734	0	75,445	2,017,635	10.00
11.00	01100	CAFETERIA	0	0	0	0	69,134	11.00
13.00	01300	NURSING ADMINISTRATION	476,470	2,078	0	1,047	0	13.00
15.00	01500	PHARMACY	5,093	6,043	0	3,045	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	174,181	12,191	0	6,142	0	16.00
17.00	01700	SOCIAL SERVICE	290,270	3,533	0	1,780	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,529,897	591,890	150,998	298,228	1,555,599	30.00
ANCILLARY SERVICE COST CENTERS								
69.00	06900	ELECTROCARDIOLOGY	249,673	70,668	0	35,607	0	69.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	745,612	277,044	0	139,591	0	90.00
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,638,648	1,144,143	150,998	560,885	1,624,733	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	COMMUNITY RELATIONS	0	0	0	0	0	191.01
191.02	19102	RETAIL PHARMACY	0	0	0	0	0	191.02
191.03	19103	NON HOSPITAL O/P	622,934	58,373	0	29,412	0	191.03
191.04	19104	CHEMICAL DEPENDENCY/S.A.F.E.	710,774	187,761	35,366	94,605	392,902	191.04
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)	8,972,356	1,390,277	186,364	684,902	2,017,635	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
5/24/2021 10:30 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	69,134					11.00
13.00	01300	NURSING ADMINISTRATION	3,737	1,648,778				13.00
15.00	01500	PHARMACY	0	0	26,638			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,242	0	0	620,802		16.00
17.00	01700	SOCIAL SERVICE	4,111	0	0	0	1,009,694	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	39,238	1,597,254	26,638	521,474	841,412	30.00
ANCILLARY SERVICE COST CENTERS								
69.00	06900	ELECTROCARDIOLOGY	1,495	0	0	0	0	69.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,605	0	0	49,664	0	90.00
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,428	1,597,254	26,638	571,138	841,412	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	COMMUNITY RELATIONS	0	0	0	0	0	191.01
191.02	19102	RETAIL PHARMACY	0	0	0	0	0	191.02
191.03	19103	NON HOSPITAL O/P	6,727	0	0	0	0	191.03
191.04	19104	CHEMICAL DEPENDENCY/S.A.F.E.	5,979	51,524	0	49,664	168,282	191.04
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)	69,134	1,648,778	26,638	620,802	1,009,694	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
5/24/2021 10:30 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
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
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,232,724	0	21,232,724	30.00
ANCILLARY SERVICE COST CENTERS						
69.00	06900	ELECTROCARDIOLOGY	968,143	0	968,143	69.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,041,281	0	3,041,281	90.00
OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,242,148	0	25,242,148	118.00
NONREIMBURSABLE COST CENTERS						
191.00	19100	RESEARCH	0	0	0	191.00
191.01	19101	COMMUNITY RELATIONS	0	0	0	191.01
191.02	19102	RETAIL PHARMACY	0	0	0	191.02
191.03	19103	NON HOSPITAL O/P	2,241,142	0	2,241,142	191.03
191.04	19104	CHEMICAL DEPENDENCY/S.A.F.E.	3,435,409	0	3,435,409	191.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	30,918,699	0	30,918,699	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
5/24/2021 10:30 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	22,676	4,808	27,484	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	582,723	123,565	706,288	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	29,361	6,226	35,587	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,671	3,959	22,630	8.00
9.00	00900	HOUSEKEEPING	0	33,985	7,206	41,191	9.00
10.00	01000	DIETARY	0	254,652	53,999	308,651	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,534	749	4,283	13.00
15.00	01500	PHARMACY	0	10,278	2,179	12,457	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,733	4,396	25,129	16.00
17.00	01700	SOCIAL SERVICE	0	6,008	1,274	7,282	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,006,625	213,455	1,220,080	30.00
ANCILLARY SERVICE COST CENTERS							
69.00	06900	ELECTROCARDIOLOGY	0	120,185	25,485	145,670	69.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	471,167	99,910	571,077	90.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,580,598	547,211	3,127,809	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	RESEARCH	0	0	0	0	191.00
191.01	19101	COMMUNITY RELATIONS	0	0	0	0	191.01
191.02	19102	RETAIL PHARMACY	0	0	0	0	191.02
191.03	19103	NON HOSPITAL O/P	0	99,275	21,051	120,326	191.03
191.04	19104	CHEMICAL DEPENDENCY/S.A.F.E.	0	319,324	67,712	387,036	191.04
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,999,197	635,974	3,635,171	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
5/24/2021 10:30 am

Cost Center Description			ADMINISTRATIVE E & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	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	713,578					5.00
6.00	00600	MAINTENANCE & REPAIRS	32,087	68,182				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,048	538	27,216			8.00
9.00	00900	HOUSEKEEPING	15,346	980	0	57,517		9.00
10.00	01000	DIETARY	41,369	7,343	0	6,336	364,200	10.00
11.00	01100	CAFETERIA	0	0	0	0	12,479	11.00
13.00	01300	NURSING ADMINISTRATION	37,894	102	0	88	0	13.00
15.00	01500	PHARMACY	405	296	0	256	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,853	598	0	516	0	16.00
17.00	01700	SOCIAL SERVICE	23,086	173	0	149	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	360,261	29,028	22,051	25,044	280,799	30.00
ANCILLARY SERVICE COST CENTERS								
69.00	06900	ELECTROCARDIOLOGY	19,857	3,466	0	2,990	0	69.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	59,300	13,587	0	11,723	0	90.00
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	607,506	56,111	22,051	47,102	293,278	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	COMMUNITY RELATIONS	0	0	0	0	0	191.01
191.02	19102	RETAIL PHARMACY	0	0	0	0	0	191.02
191.03	19103	NON HOSPITAL O/P	49,543	2,863	0	2,470	0	191.03
191.04	19104	CHEMICAL DEPENDENCY/S.A.F.E.	56,529	9,208	5,165	7,945	70,922	191.04
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)	713,578	68,182	27,216	57,517	364,200	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
5/24/2021 10:30 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	12,479					11.00
13.00	01300	NURSING ADMINISTRATION	675	44,520				13.00
15.00	01500	PHARMACY	0	0	13,414			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	405	0	0	40,855		16.00
17.00	01700	SOCIAL SERVICE	742	0	0	0	32,322	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,082	43,129	13,414	34,319	26,935	30.00
ANCILLARY SERVICE COST CENTERS								
69.00	06900	ELECTROCARDIOLOGY	270	0	0	0	0	69.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,012	0	0	3,268	0	90.00
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,186	43,129	13,414	37,587	26,935	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	COMMUNITY RELATIONS	0	0	0	0	0	191.01
191.02	19102	RETAIL PHARMACY	0	0	0	0	0	191.02
191.03	19103	NON HOSPITAL O/P	1,214	0	0	0	0	191.03
191.04	19104	CHEMICAL DEPENDENCY/S.A.F.E.	1,079	1,391	0	3,268	5,387	191.04
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)	12,479	44,520	13,414	40,855	32,322	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
5/24/2021 10:30 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
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
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,072,923	0	2,072,923	30.00
ANCILLARY SERVICE COST CENTERS						
69.00	06900	ELECTROCARDIOLOGY	172,682	0	172,682	69.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	661,514	0	661,514	90.00
OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,907,119	0	2,907,119	118.00
NONREIMBURSABLE COST CENTERS						
191.00	19100	RESEARCH	0	0	0	191.00
191.01	19101	COMMUNITY RELATIONS	0	0	0	191.01
191.02	19102	RETAIL PHARMACY	0	0	0	191.02
191.03	19103	NON HOSPITAL O/P	178,326	0	178,326	191.03
191.04	19104	CHEMICAL DEPENDENCY/S.A.F.E.	549,726	0	549,726	191.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,635,171	0	3,635,171	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-4012

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

Worksheet B-1

Date/Time Prepared:
5/24/2021 10:30 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	101,841				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		101,841			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	770	770	15,014,874		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,787	19,787	3,983,616	-8,972,356	5.00
6.00	00600	MAINTENANCE & REPAIRS	997	997	277,450	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	634	634	0	0	8.00
9.00	00900	HOUSEKEEPING	1,154	1,154	0	0	9.00
10.00	01000	DIETARY	8,647	8,647	273,610	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	120	120	807,756	0	13.00
15.00	01500	PHARMACY	349	349	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	704	704	193,541	0	16.00
17.00	01700	SOCIAL SERVICE	204	204	486,326	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	34,181	34,181	5,887,213	0	30.00
ANCILLARY SERVICE COST CENTERS							
69.00	06900	ELECTROCARDIOLOGY	4,081	4,081	234,483	0	69.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	15,999	15,999	845,500	0	90.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87,627	87,627	12,989,495	-8,972,356	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	RESEARCH	0	0	0	0	191.00
191.01	19101	COMMUNITY RELATIONS	0	0	0	0	191.01
191.02	19102	RETAIL PHARMACY	0	0	0	0	191.02
191.03	19103	NON HOSPITAL O/P	3,371	3,371	1,043,964	0	191.03
191.04	19104	CHEMICAL DEPENDENCY/S.A.F.E.	10,843	10,843	981,415	0	191.04
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)	2,999,197	635,974	3,944,844	8,972,356	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	29.449799	6.244774	0.262729	0.408831	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			27,484	713,578	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001830	0.032515	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: 26-4012

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

Worksheet B-1

Date/Time Prepared:
5/24/2021 10:30 am

Cost Center Description		MAINTENANCE & REPAIRS (HOSPITAL S QUARE FEE)	LAUNDRY & LINEN SERVICE (PATIENT DA YS)	HOUSEKEEPING (HOSPITAL S QUARE FEE)	DIETARY (MEALS SERVED)	CAFETERIA (PAID FTES)	
		6.00	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
6.00	00600	MAINTENANCE & REPAIRS	80,287				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	634	31,723			8.00
9.00	00900	HOUSEKEEPING	1,154	0	78,499		9.00
10.00	01000	DIETARY	8,647	0	8,647	104,101	10.00
11.00	01100	CAFETERIA	0	0	0	3,567	11.00
13.00	01300	NURSING ADMINISTRATION	120	0	120	0	13.00
15.00	01500	PHARMACY	349	0	349	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	704	0	704	0	16.00
17.00	01700	SOCIAL SERVICE	204	0	204	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	34,181	25,703	34,181	80,262	30.00
ANCILLARY SERVICE COST CENTERS							
69.00	06900	ELECTROCARDIOLOGY	4,081	0	4,081	0	69.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	15,999	0	15,999	0	90.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,073	25,703	64,285	83,829	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	RESEARCH	0	0	0	0	191.00
191.01	19101	COMMUNITY RELATIONS	0	0	0	0	191.01
191.02	19102	RETAIL PHARMACY	0	0	0	0	191.02
191.03	19103	NON HOSPITAL O/P	3,371	0	3,371	0	191.03
191.04	19104	CHEMICAL DEPENDENCY/S.A.F.E.	10,843	6,020	10,843	20,272	191.04
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)	1,390,277	186,364	684,902	2,017,635	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.316340	5.874728	8.724977	19.381514	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	68,182	27,216	57,517	364,200	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.849228	0.857926	0.732710	3.498525	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: 26-4012

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

Worksheet B-1

Date/Time Prepared:
5/24/2021 10:30 am

Cost Center Description		NURSING ADMINISTRATION (NUR ADMIN FTE)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
		13.00	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
6.00	00600	MAINTENANCE & REPAIRS					6.00
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	16,640				13.00
15.00	01500	PHARMACY	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	10,400		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	24,960	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	16,120	100	8,736	20,800	30.00
ANCILLARY SERVICE COST CENTERS							
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	832	0	90.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,120	100	9,568	20,800	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	RESEARCH	0	0	0	0	191.00
191.01	19101	COMMUNITY RELATIONS	0	0	0	0	191.01
191.02	19102	RETAIL PHARMACY	0	0	0	0	191.02
191.03	19103	NON HOSPITAL O/P	0	0	0	0	191.03
191.04	19104	CHEMICAL DEPENDENCY/S.A.F.E.	520	0	832	4,160	191.04
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)	1,648,778	26,638	620,802	1,009,694	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	99.085216	266.380000	59.692500	40.452484	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	44,520	13,414	40,855	32,322	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.675481	134.140000	3.928365	1.294952	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
5/24/2021 10:30 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	21,232,724		21,232,724	1,748	21,234,472	30.00	
ANCILLARY SERVICE COST CENTERS									
69.00	06900	ELECTROCARDIOLOGY	968,143		968,143	6,912	975,055	69.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	3,041,281		3,041,281	1,043	3,042,324	90.00	
OTHER REIMBURSABLE COST CENTERS									
99.00	09900	CMHC	0		0		0	99.00	
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	25,242,148	0	25,242,148	9,703	25,251,851	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	25,242,148	0	25,242,148	9,703	25,251,851	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
5/24/2021 10:30 am

			Title XVIII		Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	53,986,650		53,986,650			30.00
	ANCILLARY SERVICE COST CENTERS							
69.00	06900	ELECTROCARDIOLOGY	804,524	2,254,204	3,058,728	0.316518	0.000000	69.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	525	5,863,459	5,863,984	0.518637	0.000000	90.00
	OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0			99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	54,791,699	8,117,663	62,909,362			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	54,791,699	8,117,663	62,909,362			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
5/24/2021 10:30 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS					
69.00	06900	ELECTROCARDIOLOGY	0.318778		69.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.518815		90.00
OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC			99.00
101.00	10100	HOME HEALTH AGENCY			101.00
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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
5/24/2021 10:30 am

				Title XIX		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	21,232,724		21,232,724	1,748	21,234,472	30.00	
ANCILLARY SERVICE COST CENTERS									
69.00	06900	ELECTROCARDIOLOGY	968,143		968,143	6,912	975,055	69.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	3,041,281		3,041,281	1,043	3,042,324	90.00	
OTHER REIMBURSABLE COST CENTERS									
99.00	09900	CMHC	0		0		0	99.00	
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	25,242,148	0	25,242,148	9,703	25,251,851	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	25,242,148	0	25,242,148	9,703	25,251,851	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
5/24/2021 10:30 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	53,986,650		53,986,650		
ANCILLARY SERVICE COST CENTERS							
69.00	06900	ELECTROCARDIOLOGY	804,524	2,254,204	3,058,728	0.316518	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	525	5,863,459	5,863,984	0.518637	0.000000
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0		
101.00	10100	HOME HEALTH AGENCY	0	0	0		
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (see instructions)	54,791,699	8,117,663	62,909,362		
201.00		Less Observation Beds					
202.00		Total (see instructions)	54,791,699	8,117,663	62,909,362		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
5/24/2021 10:30 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC				99.00
101.00	10100	HOME HEALTH AGENCY				101.00
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 ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
5/24/2021 10:30 am

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		2,072,923	0	2,072,923	25,703	80.65	30.00
200.00	Total (lines 30 through 199)		2,072,923		2,072,923	25,703		200.00
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		6,020	485,513				
200.00	Total (lines 30 through 199)		6,020	485,513				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 26-4012		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part II Date/Time Prepared: 5/24/2021 10:30 am	
				Title XVIII		Hospital		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)			
		1.00	2.00	3.00	4.00	5.00			
69.00	ANCILLARY SERVICE COST CENTERS							69.00	
	06900 ELECTROCARDIOLOGY	172,682	3,058,728	0.056455	280,763	15,850			
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	661,514	5,863,984	0.112810	0	0	90.00		
200.00	Total (lines 50 through 199)	834,196	8,922,712		280,763	15,850	200.00		

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 26-4012		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 5/24/2021 10:30 am		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	25,703	0.00	6,020	30.00		
200.00		Total (lines 30 through 199)		0	0	25,703		6,020	200.00		
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0						30.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
5/24/2021 10:30 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
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: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
5/24/2021 10:30 am

			Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,058,728	0.000000	69.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	5,863,984	0.000000	90.00
200.00		Total (lines 50 through 199)	0	0	0	8,922,712		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 26-4012

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2021 10:30 am

				Title XVIII		Hospital	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
69.00	ANCILLARY SERVICE COST CENTERS							
	06900	ELECTROCARDIOLOGY	0.000000	280,763	0	532,052	0	69.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	4,245,400	0	90.00
200.00		Total (lines 50 through 199)		280,763	0	4,777,452	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
5/24/2021 10:30 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
69.00	06900	ELECTROCARDIOLOGY	0.316518	532,052	0	0	168,404	69.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.518637	4,245,400	0	0	2,201,822	90.00
200.00		Subtotal (see instructions)		4,777,452	0	0	2,370,226	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		4,777,452	0	0	2,370,226	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
5/24/2021 10:30 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0					90.00
200.00		Subtotal (see instructions)	0	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	0					202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
5/24/2021 10:30 am

			Title XIX		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00	5.00
	ANCILLARY SERVICE COST CENTERS							
69.00	06900	ELECTROCARDIOLOGY	0.316518	0	4,956	0	0	69.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.518637	0	43,775	0	0	90.00
200.00		Subtotal (see instructions)		0	48,731	0	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	48,731	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
5/24/2021 10:30 am

			Title XIX		Hospital	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
			ANCILLARY SERVICE COST CENTERS			
69.00	06900	ELECTROCARDIOLOGY	1,569	0		69.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	22,703	0		90.00
200.00		Subtotal (see instructions)	24,272	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	24,272	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-4012	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 5/24/2021 10:30 am	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			25,703	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			25,703	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)			25,703	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			6,020	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			21,234,472	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			21,234,472	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			21,234,472	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)			826.15	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			4,973,423	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			4,973,423	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-4012

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

Worksheet D-1

Date/Time Prepared:
5/24/2021 10:30 am

Cost Center Description		Title XVIII		Hospital		PPS	
		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)					89,501	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,961,666	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)					485,513	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					15,850	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					501,363	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,460,303	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-4012

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

Worksheet D-1

Date/Time Prepared:
5/24/2021 10:30 am

		Title XVIII		Hospital	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,072,923	21,234,472	0.097621	0	0
91.00	Nursing School cost	0	21,234,472	0.000000	0	0
92.00	Allied health cost	0	21,234,472	0.000000	0	0
93.00	All other Medical Education	0	21,234,472	0.000000	0	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-4012	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 5/24/2021 10:30 am	
		Title XVIII	Hospital	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		12,642,000		30.00
ANCILLARY SERVICE COST CENTERS					
69.00	06900 ELECTROCARDIOLOGY	0.318778	280,763	89,501	69.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.518815	0	0	90.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		280,763	89,501	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)		280,763		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-4012	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 5/24/2021 10:30 am	
		Title XIX	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		1,209,600		30.00
ANCILLARY SERVICE COST CENTERS					
69.00	06900 ELECTROCARDIOLOGY	0.316518	0	0	69.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.518637	0	0	90.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-4012	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 5/24/2021 10:30 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)		2,370,226	2.00
3.00	OPPI payments		1,966,164	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)		0	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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		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)		0	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)		1,966,164	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		405,673	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)		1,560,491	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)		1,560,491	30.00
31.00	Primary payer payments		4,776	31.00
32.00	Subtotal (line 30 minus line 31)		1,555,715	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)		256,960	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		167,024	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		156,129	36.00
37.00	Subtotal (see instructions)		1,722,739	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,722,739	40.00
40.01	Sequestration adjustment (see instructions)		11,370	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		1,844,820	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-133,451	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
5/24/2021 10:30 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,117,859		1,789,620	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	08/19/2020	142,300	08/19/2020	55,200	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)		142,300		55,200	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)		5,260,159		1,844,820	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		225,733		133,451	6.02
7.00	Total Medicare program liability (see instructions)		5,034,426		1,711,369	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		Provider CCN: 26-4012	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part II Date/Time Prepared: 5/24/2021 10:30 am
		Title XVIII	Hospital	PPS
			1.00	
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			5,079,984 1.00
2.00	Net IPF PPS Outlier Payments			128,718 2.00
3.00	Net IPF PPS ECT Payments			55,558 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			70.226776 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			5,264,260 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			5,264,260 16.00
17.00	Primary payer payments			22,388 17.00
18.00	Subtotal (line 16 less line 17).			5,241,872 18.00
19.00	Deductibles			313,009 19.00
20.00	Subtotal (line 18 minus line 19)			4,928,863 20.00
21.00	Coinsurance			159,401 21.00
22.00	Subtotal (line 20 minus line 21)			4,769,462 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			459,096 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			298,412 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			330,387 25.00
26.00	Subtotal (sum of lines 22 and 24)			5,067,874 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			5,067,874 31.00
31.01	Sequestration adjustment (see instructions)			33,448 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			5,260,159 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			-225,733 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			128,718 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 26-4012

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

Worksheet G

Date/Time Prepared:
5/24/2021 10:30 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	0	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,264,723	0	0	0	4.00
5.00	Other receivable	115,674	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-731,107	0	0	0	6.00
7.00	Inventory	86,775	0	0	0	7.00
8.00	Prepaid expenses	535,338	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,271,403	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	2,936,693	0	0	0	15.00
16.00	Accumulated depreciation	-1,434,054	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	47,099	0	0	0	21.00
22.00	Accumulated depreciation	-47,099	0	0	0	22.00
23.00	Major movable equipment	2,845,857	0	0	0	23.00
24.00	Accumulated depreciation	-2,247,384	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	2,101,112	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	100,144	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	10,362,300	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,462,444	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	17,834,959	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,731,344	0	0	0	37.00
38.00	Salaries, wages, and fees payable	386,038	0	0	0	38.00
39.00	Payroll taxes payable	611,620	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	914,665	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,643,667	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-10,563,165	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-10,563,165	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-4,919,498	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	22,754,457	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	22,754,457	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	17,834,959	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 26-4012

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

Worksheet G-1

Date/Time Prepared:
5/24/2021 10:30 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		23,977,985		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,223,531				2.00
3.00	Total (sum of line 1 and line 2)		22,754,454		0		3.00
4.00	ROUNDING	3		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)		3		0		10.00
11.00	Subtotal (line 3 plus line 10)		22,754,457		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)		22,754,457		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	ROUNDING		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: 26-4012

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
5/24/2021 10:30 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	53,986,650		53,986,650	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	53,986,650		53,986,650	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)	53,986,650		53,986,650	17.00
18.00	Ancillary services	804,524	2,254,204	3,058,728	18.00
19.00	Outpatient services	525	5,863,459	5,863,984	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	779,870	779,870	27.00
27.01	NON HOSPITAL O/P	0	10,741,500	10,741,500	27.01
27.02	CHEMICAL DEPENDENCY	4,814,700	919,425	5,734,125	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	59,606,399	20,558,458	80,164,857	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,150,512		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)		31,150,512		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 26-4012

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

Worksheet G-3

Date/Time Prepared:
5/24/2021 10:30 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	80,164,857	1.00
2.00	Less contractual allowances and discounts on patients' accounts	51,870,464	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,294,393	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,150,512	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,856,119	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	760	6.00
7.00	Income from investments	-2,645	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	17,903	14.00
15.00	Revenue from rental of living quarters	38,400	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	2,921	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	3,181	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	26,419	24.00
24.50	COVID-19 PHE Funding	1,545,649	24.50
25.00	Total other income (sum of lines 6-24)	1,632,588	25.00
26.00	Total (line 5 plus line 25)	-1,223,531	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)	-1,223,531	29.00