

Health Financial Systems

ST. MARGARETS HEALTH - PERU

In Lieu of Form CMS-2552-10

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

FORM APPROVED

OMB NO. 0938-0050

EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION
AND SETTLEMENT SUMMARY

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet S
Parts I-III
Date/Time Prepared:
1/28/2022 3:14 pm

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 1/28/2022	Time: 3:14 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) AS Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED 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 submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. MARGARETS HEALTH - PERU (14-0234) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
1		X	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification to be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

Encryption information

ECR: Date: 1/28/2022 Time: 3:14 pm
tAbB6LStd3w.1wpaRZrmcwpV0KL80
a59Cj0nsIWRPffjs0-OCn.INWnkqITb
RwralhjlKLOukksf

		Rwraihj1KLU0KXSF					
		Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
			Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY							
1.00	Hospital	0	66,715	-119,345	0	0	1.00
2.00	Subprovider - IPF	0	0	0	0	0	2.00
3.00	Subprovider - IRF	0	0	0	0	0	3.00
5.00	Swing Bed - SNF	0	0	0	0	0	5.00
6.00	Swing Bed - NF	0	0	0	0	0	6.00
10.00	RURAL HEALTH CLINIC I	0	0	23,137	0	0	10.00
10.01	RURAL HEALTH CLINIC II	0	0	22,387	0	0	10.01
10.02	RURAL HEALTH CLINIC III	0	0	-85,998	0	0	10.02
10.03	RURAL HEALTH CLINIC IV	0	0	90,483	0	0	10.03
10.04	RURAL HEALTH CLINIC V	0	0	78,213	0	0	10.04
200.00	Total	0	66,715	8,877	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: 14-0234		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 1/28/2022 2:57 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 925 WEST STREET			PO Box:				1.00	
2.00	City: PERU			State: IL		Zip Code: 61354		County: LA SALLE 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			ST. MARGARETS HEALTH - PERU	140234	99914	1	07/01/1966	N P O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF			SWING BED	14U234	99914		07/01/1991	N P N
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			VALLEY HOSPICE	141533	99914		04/01/1985	
15.00	Hospital-Based Health Clinic - RHC			WOMENS HEALTH CARE CENTER	148564	99914		08/22/2016	N N O
15.01	Hospital-Based Health Clinic - RHC I			ILASALLE MEDICAL CLINIC	148565	99914		09/01/2016	N N O
15.02	Hospital-Based Health Clinic - RHC III			PERU MEDICAL CLINIC	148562	99914		09/08/2016	N N O
15.03	Hospital-Based Health Clinic - RHC IV			PERU PRIMARY CARE CLINIC	148563	99914		09/12/2016	N N O
15.04	Hospital-Based Health Clinic - RHC V			OGLESBY MEDICAL CLINIC	148561	99914		08/25/2016	N N O
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)						07/01/2020	06/30/2021	20.00
21.00	Type of Control (see instructions)						2		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.04

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0234		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 1/28/2022 2:57 pm	
		1.00	2.00	3.00			
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	N			23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
		1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	870	0	0	0	215	0
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	0
		Urban/Rural Status				Date of Geographic Reclassification	
		1.00				2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:				Ending:	
		1.00				2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1				37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPSS 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.	07/01/2020 06/30/2021				38.00	
		Y/N				Y/N	
		1.00				2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	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)	Y				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)	Y				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				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				47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N				48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N				57.00	

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			V 1.00	XVIII 2.00	XIX 3.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00
		Y/N	IME	Direct GME	
		1.00	2.00	3.00	
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
61.01	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
61.20	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
					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
62.01	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
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

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				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0234		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 1/28/2022 2:57 pm	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00	
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
				1.00	2.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	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:	342,524	0			118.01	
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	Y			120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0234		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 1/28/2022 2:57 pm	
		1.00		2.00			
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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		2.00			
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		2.00			
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	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
		1.00		2.00			
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	
		Zip Code		CBSA		FTE/Campus	
		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		2.00		3.00	
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)			9.99		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0234	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 1/28/2022 2:57 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0234		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part II Date/Time Prepared: 1/28/2022 2:57 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			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.			Y			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider 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 programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					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)			N		N	
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	12/30/2021	Y	12/30/2021
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0234

Period:
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		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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		Y		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.		Y		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.		Y		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.		Y		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.		N		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.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LISA	LYNCH		41.00
42.00	Enter the employer/company name of the cost report preparer	ST. MARGARETS HEALTH - PERU			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-780-3574	LISA.LYNCH@IVCH.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

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Period:
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		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.	AVP OF FINANCE		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

Health Financial Systems		ST. MARGARETS HEALTH - PERU		Non-CMS HFS Worksheet	
HFS Supplemental Information		Provider CCN: 14-0234	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part IX Date/Time Prepared: 1/28/2022 2:57 pm	
			Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)		N	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)		N	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)		N	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?		N	N	3.01
3.02	Does Title XIX transfer managed care (HMO) days from Worksheet S-3, Part I, column 7, sum of lines 2, 3, and 4 to Worksheet E-4, column 2, line 26?			Y	3.02
			Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N	N	5.00
			Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)		N	Y	6.00
PASS THROUGH COST					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)		N	Y	7.00
RHC					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	8.00
FQHC					
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	9.00
			State 1.00		
STATE MEDICAID FORMS					
10.00	Select the state when using state Medicaid forms.				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0234

Period:
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To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
1/28/2022 2:57 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	45	16,425	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)		45	16,425	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		49	17,885	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.03 RURAL HEALTH CLINIC IV	88.03				0	26.03
26.04 RURAL HEALTH CLINIC V	88.04				0	26.04
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		49				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
1/28/2022 2:57 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,464	764	4,285			1.00
2.00	HMO and other (see instructions)	545	51				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	45	0	53			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)	2,509	764	4,338			7.00
8.00	INTENSIVE CARE UNIT	348	0	864			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		270	576			13.00
14.00	Total (see instructions)	2,857	1,034	5,778	0.00	415.18	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	4.17	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	313	0	9,188	0.00	20.62	26.00
26.01	RURAL HEALTH CLINIC II	1,011	0	4,084	0.00	8.58	26.01
26.02	RURAL HEALTH CLINIC III	3,263	0	5,321	0.00	10.71	26.02
26.03	RURAL HEALTH CLINIC IV	1,957	0	8,043	0.00	12.73	26.03
26.04	RURAL HEALTH CLINIC V	1,220	0	5,431	0.00	11.86	26.04
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	483.85	27.00
28.00	Observation Bed Days		350	2,023			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	141			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
1/28/2022 2:57 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	808	355	1,490	1.00
2.00 HMO and other (see instructions)			133	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	808	355	1,490	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.02 RURAL HEALTH CLINIC III	0.00					26.02
26.03 RURAL HEALTH CLINIC IV	0.00					26.03
26.04 RURAL HEALTH CLINIC V	0.00					26.04
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
1/28/2022 2:57 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	29,982,975	0	29,982,975	1,006,413.14	29.79
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		4,618,516	0	4,618,516	28,747.25	160.66
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		5,280,085	0	5,280,085	134,172.67	39.35
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,369,121	0	1,369,121	44,595.58	30.70
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,664,769	0	1,664,769	22,938.45	72.58
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		4,867,033	0	4,867,033		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		303,681	0	303,681		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		299,895	0	299,895		
24.00	Wage-related costs (RHC/FQHC)		1,028,171	0	1,028,171		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
1/28/2022 2:57 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	163,145	0	163,145	6,243.13	26.13
27.00	Administrative & General	5.00	3,451,552	0	3,451,552	178,470.72	19.34
28.00	Administrative & General under contract (see inst.)		52,900	0	52,900	1,046.71	50.54
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	612,630	0	612,630	24,804.34	24.70
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00
32.00	Housekeeping	9.00	6,642	0	6,642	173.33	38.32
33.00	Housekeeping under contract (see instructions)		687,939	0	687,939	51,240.86	13.43
34.00	Dietary	10.00	217,875	-3,736	214,139	8,494.82	25.21
35.00	Dietary under contract (see instructions)		495,388	0	495,388	40,373.92	12.27
36.00	Cafeteria	11.00	0	3,736	3,736	148.21	25.21
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	619,618	0	619,618	16,001.00	38.72
39.00	Central Services and Supply	14.00	170,742	0	170,742	9,444.00	18.08
40.00	Pharmacy	15.00	684,768	0	684,768	17,929.71	38.19
41.00	Medical Records & Medical Records Library	16.00	504,758	0	504,758	28,574.00	17.66
42.00	Social Service	17.00	186,314	0	186,314	6,463.00	28.83
43.00	Other General Service	18.00	0	0	0	0.00	0.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part III
Date/Time Prepared:
1/28/2022 2:57 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	21,320,601	0	21,320,601	936,154.71	22.77	1.00
2.00	Excluded area salaries (see instructions)	1,369,121	0	1,369,121	44,595.58	30.70	2.00
3.00	Subtotal salaries (line 1 minus line 2)	19,951,480	0	19,951,480	891,559.13	22.38	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,664,769	0	1,664,769	22,938.45	72.58	4.00
5.00	Subtotal wage-related costs (see inst.)	4,867,033	0	4,867,033	0.00	24.39	5.00
6.00	Total (sum of lines 3 thru 5)	26,483,282	0	26,483,282	914,497.58	28.96	6.00
7.00	Total overhead cost (see instructions)	7,854,271	0	7,854,271	389,407.75	20.17	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0234	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part IV Date/Time Prepared: 1/28/2022 2:57 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		836,013	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		0	8.02
8.03	Health Insurance (Purchased)		3,296,848	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		254,858	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		4,846	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		70,113	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		140,114	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		1,856,899	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		22,331	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		16,758	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		6,498,780	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part V
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,664,769	6,498,780	1.00
2.00	Hospital	1,664,769	5,461,129	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	51,945	13.00
14.00	Hospital-Based Health Clinic RHC	0	325,881	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	123,468	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	170,258	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	197,636	14.03
14.04	Hospital-Based Health Clinic RHC 4	0	168,463	14.04
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0234 Component CCN: 14-8564		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8 Date/Time Prepared: 1/28/2022 2:57 pm	
				RHC I					
				1.00					
Clinic Address and Identification									
1.00	Street			920 WEST STREET				1.00	
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			PERU IL 61354				2.00	
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)							4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)							5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)							6.00	
7.00	Appalachian Regional Commission							7.00	
8.00	Look-Alikes							8.00	
9.00	OTHER (SPECIFY)							9.00	
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC			08:00		19:00		08:00	
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			Y				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							14.00	
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			LASALLE				2.00	
				Tuesday	Wednesday	Thursday			
				to	from	to	from	to	
				6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)									
11.00	CLINIC			18:50		08:00		19:00	
				08:00		19:00		08:00	
				18:50				11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0234 Component CCN: 14-8564		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8 Date/Time Prepared: 1/28/2022 2:57 pm	
						RHC I			
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC	08:00	17:00						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0234 Component CCN: 14-8565		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8 Date/Time Prepared: 1/28/2022 2:57 pm	
				RHC II					
				1.00					
Clinic Address and Identification									
1.00	Street			128 BUCKLIN STREET				1.00	
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			LASALLE IL 61301				2.00	
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)							4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)							5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)							6.00	
7.00	Appalachian Regional Commission							7.00	
8.00	Look-Alikes							8.00	
9.00	OTHER (SPECIFY)							9.00	
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC			07:00		19:00		07:00	
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			Y				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							14.00	
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			LASALLE				2.00	
				Tuesday	Wednesday	Thursday			
				to	from	to	from	to	
				6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)									
11.00	CLINIC			18:00		07:00		19:00	
				07:00		18:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0234 Component CCN: 14-8565		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8 Date/Time Prepared: 1/28/2022 2:57 pm		
						RHC II				
				Friday		Saturday				
				from	to	from	to			
				11.00	12.00	13.00	14.00			
11.00	Facility hours of operations (1)									
	CLINIC	07:00	17:00						11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0234 Component CCN: 14-8562		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8 Date/Time Prepared: 1/28/2022 2:57 pm	
				RHC III					
				1.00					
Clinic Address and Identification									
1.00	Street			710 PEORIA STREET				1.00	
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			PERU IL 61354				2.00	
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)							4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)							5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)							6.00	
7.00	Appalachian Regional Commission							7.00	
8.00	Look-Alikes							8.00	
9.00	OTHER (SPECIFY)							9.00	
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC			08:30		17:00		08:30	
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			Y				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							14.00	
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			LSALLE				2.00	
				Tuesday	Wednesday	Thursday			
				to	from	to	from	to	
				6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)									
11.00	CLINIC			17:00		08:30		17:00	
				08:30		19:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0234 Component CCN: 14-8562		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8 Date/Time Prepared: 1/28/2022 2:57 pm	
						RHC III			
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1)								
	CLINIC	08:30	17:00						11.00

Health Financial Systems		ST. MARGARETS HEALTH - PERU		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0234 Component CCN: 14-8563		Period: From 07/01/2020 To 06/30/2021 Worksheet S-8 Date/Time Prepared: 1/28/2022 2:57 pm	
		RHC IV			
		1.00			
1.00	Clinic Address and Identification Street			920 WEST STREET BLDG B SUITE 100 1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		PERU	IL	61354 2.00
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
		Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0 10.00
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		5.00	
		Facility hours of operations (1)			
11.00	CLINIC		08:00	17:00	08:00 11.00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?			Y	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0 13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number		14.00		
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00
		County		4.00	
2.00	City, State, ZIP Code, County		LASALLE 2.00		
		Tuesday	Wednesday		Thursday
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
		Facility hours of operations (1)			
11.00	CLINIC		17:00	08:00	17:00
		08:00		17:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0234

Period:

Worksheet S-8

Component CCN: 14-8563

From 07/01/2020
To 06/30/2021Date/Time Prepared:
1/28/2022 2:57 pm

RHC IV

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1)						
	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0234 Component CCN: 14-8561		Period: From 07/01/2020 To 06/30/2021		Worksheet S-8 Date/Time Prepared: 1/28/2022 2:57 pm	
				RHC V					
				1.00					
Clinic Address and Identification									
1.00	Street			520 W. WALNUT STREET				1.00	
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			OGLESBY IL 61348				2.00	
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)							4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)							5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)							6.00	
7.00	Appalachian Regional Commission							7.00	
8.00	Look-Alikes							8.00	
9.00	OTHER (SPECIFY)							9.00	
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC			08:00		20:00		08:00	
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			Y				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							14.00	
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			LASALLE				2.00	
				Tuesday	Wednesday	Thursday			
				to	from	to	from	to	
				6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)									
11.00	CLINIC			20:00		08:00		20:00	
				08:00		20:00		08:00	
				20:00		08:00		20:00	
				11.00					

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0234 Component CCN: 14-8561	Period: From 07/01/2020 To 06/30/2021	Worksheet S-8 Date/Time Prepared: 1/28/2022 2:57 pm	
			RHC V			
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC	08:00	16:00			11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 14-0234

Period:

Worksheet S-9

Hospice CCN: 14-1533

From 07/01/2020

PARTS I THROUGH IV

To 06/30/2021

Date/Time Prepared:

1/28/2022 2:57 pm

		Hospice I					
		Unduplicated Days					
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)
		1.00	2.00	3.00	4.00	5.00	6.00
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care						1.00
2.00	Hospice Routine Home Care						2.00
3.00	Hospice Inpatient Respite Care						3.00
4.00	Hospice General Inpatient Care						4.00
5.00	Total Hospice Days						5.00
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care						6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare						7.00
8.00	Average Length of Stay (line 5 / line 6)						8.00
9.00	Unduplicated census count						9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	2,447	0	0	2,447	11.00
12.00	Hospice Inpatient Respite Care	0	0	0	0	12.00
13.00	Hospice General Inpatient Care	0	0	0	0	13.00
14.00	Total Hospice Days	2,447	0	0	2,447	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet S-10

Date/Time Prepared:
1/28/2022 2:57 pm

				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.286183		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		7,098,987		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		30,653,926		6.00
7.00	Medicaid cost (line 1 times line 6)		8,772,633		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		1,673,646		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0		9.00
10.00	Stand-alone CHIP charges		0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,673,646		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	366,355	290,296	656,651	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	104,845	290,296	395,141	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	104,845	290,296	395,141	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		4,591,490		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		171,224		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		263,422		27.01
28.00	Non-Medicare bad debt expense (see instructions)		4,328,068		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,330,817		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,725,958		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,399,604		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,093,976	1,093,976	90,999	1,184,975
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,280,466	1,280,466	1,392,479	2,672,945
3.00	00300	OTHER CAP REL COSTS		0	0	0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	163,145	6,396,963	6,560,108	0	6,560,108
5.00	00500	ADMINISTRATIVE & GENERAL	3,451,552	11,431,763	14,883,315	-162,118	14,721,197
7.00	00700	OPERATION OF PLANT	612,630	2,300,190	2,912,820	-4,910	2,907,910
8.00	00800	LAUNDRY & LINEN SERVICE	0	190,569	190,569	0	190,569
9.00	00900	HOUSEKEEPING	6,642	1,428,854	1,435,496	0	1,435,496
10.00	01000	DIETARY	217,875	1,209,494	1,427,369	-699,360	728,009
11.00	01100	CAFETERIA	0	0	0	699,360	699,360
13.00	01300	NURSING ADMINISTRATION	619,618	39,599	659,217	0	659,217
14.00	01400	CENTRAL SERVICES & SUPPLY	170,742	212,752	383,494	-162,245	221,249
15.00	01500	PHARMACY	684,768	323,763	1,008,531	-79,297	929,234
16.00	01600	MEDICAL RECORDS & LIBRARY	504,758	346,804	851,562	-773	850,789
17.00	01700	SOCIAL SERVICE	186,314	9,305	195,619	0	195,619
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,334,717	1,071,459	5,406,176	-812,794	4,593,382
31.00	03100	INTENSIVE CARE UNIT	613,770	432,461	1,046,231	0	1,046,231
43.00	04300	NURSERY	0	0	0	414,066	414,066
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	564,332	4,867,344	5,431,676	-2,146,979	3,284,697
50.01	05001	SAME DAY SURGERY	413,551	34,615	448,166	0	448,166
50.02	05002	LITHOTRIPSY	0	0	0	0	0
50.03	05003	ENDOSCOPY	228,952	338,215	567,167	-129,745	437,422
51.00	05100	RECOVERY ROOM	217,881	6,622	224,503	0	224,503
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	403,888	403,888
53.00	05300	ANESTHESIOLOGY	608,227	1,758,395	2,366,622	-1,726	2,364,896
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,322,894	2,331,028	3,653,922	-288,578	3,365,344
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	924,791	2,369,500	3,294,291	-1,427	3,292,864
64.00	06400	INTRAVENOUS THERAPY	138,601	11,557	150,158	0	150,158
65.00	06500	RESPIRATORY THERAPY	314,257	231,401	545,658	-96,357	449,301
66.00	06600	PHYSICAL THERAPY	1,127,890	393,723	1,521,613	-268,581	1,253,032
67.00	06700	OCCUPATIONAL THERAPY	136,072	4,374	140,446	0	140,446
68.00	06800	SPEECH PATHOLOGY	65,996	1,111	67,107	0	67,107
69.00	06900	ELECTROCARDIOLOGY	142,404	169,644	312,048	0	312,048
69.02	06902	CARDIAC REHAB	89,045	6,415	95,460	0	95,460
69.03	06903	WOUND CARE	643	1,050,926	1,051,569	-7,861	1,043,708
70.00	07000	ELECTROENCEPHALOGRAPHY	82,979	6,332	89,311	0	89,311
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	311,977	311,977
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,693,963	1,693,963
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,490,891	2,490,891	0	2,490,891
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,822,518	715,960	2,538,478	0	2,538,478
88.01	08801	RURAL HEALTH CLINIC II	623,281	171,751	795,032	0	795,032
88.02	08802	RURAL HEALTH CLINIC III	957,707	256,378	1,214,085	-46,038	1,168,047
88.03	08803	RURAL HEALTH CLINIC IV	1,085,617	582,075	1,667,692	0	1,667,692
88.04	08804	RURAL HEALTH CLINIC V	837,000	346,248	1,183,248	0	1,183,248
90.00	09000	CLINIC	4,082,464	1,687,629	5,770,093	1,730	5,771,823
91.00	09100	EMERGENCY	1,260,221	3,113,914	4,374,135	-38,202	4,335,933
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	51,961	41,564	93,525	0	93,525
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	639,602	639,602	0	639,602
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0
116.00	11600	HOSPICE	213,157	136,207	349,364	-471	348,893
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,878,972	51,531,839	80,410,811	61,000	80,471,811
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0
192.01	19201	MOB	0	0	0	0	0
192.02	19202	COMMUNITY HEALTH	110,031	37,915	147,946	-12,300	135,646
192.03	19203	OCCUPATIONAL MEDICINE	299,359	88,053	387,412	0	387,412
192.04	19204	FAMILY PHARMACY	0	0	0	0	0
192.05	19205	ADULT DAY CARE	0	0	0	0	0
192.06	19206	PERSONAL TOUCH	0	0	0	0	0
192.07	19207	IV HEALTH CORP	0	0	0	0	0
192.08	19208	PUBLIC RELATIONS	66,986	290,044	357,030	0	357,030
192.09	19209	UTICA MEDICAL CENTER	0	0	0	0	0
192.10	19210	OGLESBY FAMILY MEDICINE	0	0	0	0	0

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
192.11	19211	FAST CARE	0	7	7	0	7	192.11
192.12	19212	IVCH CARE TODAY	0	0	0	0	0	192.12
192.13	19213	PPCC	0	0	0	0	0	192.13
192.14	19214	ADULT MEDICINE CLINIC	0	0	0	0	0	192.14
192.15	19215	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.15
192.16	19216	STREATOR MEDICAL CLINIC	388,010	141,111	529,121	-48,700	480,421	192.16
192.17	19217	STREATOR ORTHO CLINIC	0	4,135	4,135	0	4,135	192.17
194.00	07950	OTHER PHYSICIANS OFFICES	239,617	12,598	252,215	0	252,215	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	29,982,975	52,105,702	82,088,677	0	82,088,677	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	1,184,975	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-9,094	2,663,851	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-721,033	5,839,075	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,085,316	10,635,881	5.00
7.00	00700	OPERATION OF PLANT	-28,327	2,879,583	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	190,569	8.00
9.00	00900	HOUSEKEEPING	0	1,435,496	9.00
10.00	01000	DIETARY	-30,058	697,951	10.00
11.00	01100	CAFETERIA	-66,529	632,831	11.00
13.00	01300	NURSING ADMINISTRATION	-60	659,157	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	221,249	14.00
15.00	01500	PHARMACY	-2,566	926,668	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-955	849,834	16.00
17.00	01700	SOCIAL SERVICE	0	195,619	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,497,468	3,095,914	30.00
31.00	03100	INTENSIVE CARE UNIT	-50,700	995,531	31.00
43.00	04300	NURSERY	0	414,066	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	3,284,697	50.00
50.01	05001	SAME DAY SURGERY	0	448,166	50.01
50.02	05002	LITHOTRIPSY	0	0	50.02
50.03	05003	ENDOSCOPY	0	437,422	50.03
51.00	05100	RECOVERY ROOM	0	224,503	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	403,888	52.00
53.00	05300	ANESTHESIOLOGY	-1,949,796	415,100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-875	3,364,469	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-9,634	3,283,230	60.00
64.00	06400	INTRAVENOUS THERAPY	0	150,158	64.00
65.00	06500	RESPIRATORY THERAPY	4,800	454,101	65.00
66.00	06600	PHYSICAL THERAPY	0	1,253,032	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	140,446	67.00
68.00	06800	SPEECH PATHOLOGY	0	67,107	68.00
69.00	06900	ELECTROCARDIOLOGY	-115,830	196,218	69.00
69.02	06902	CARDIAC REHAB	0	95,460	69.02
69.03	06903	WOUND CARE	0	1,043,708	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	-240	89,071	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	311,977	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,693,963	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,490,891	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-60,000	2,478,478	88.00
88.01	08801	RURAL HEALTH CLINIC II	-30,804	764,228	88.01
88.02	08802	RURAL HEALTH CLINIC III	-17,160	1,150,887	88.02
88.03	08803	RURAL HEALTH CLINIC IV	-36,000	1,631,692	88.03
88.04	08804	RURAL HEALTH CLINIC V	-50,000	1,133,248	88.04
90.00	09000	CLINIC	-3,362,225	2,409,598	90.00
91.00	09100	EMERGENCY	-2,736,114	1,599,819	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	93,525	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-639,602	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
116.00	11600	HOSPICE	0	348,893	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-15,495,586	64,976,225	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	192.00
192.01	19201	MOB	0	0	192.01
192.02	19202	COMMUNITY HEALTH	0	135,646	192.02
192.03	19203	OCCUPATIONAL MEDICINE	0	387,412	192.03
192.04	19204	FAMILY PHARMACY	0	0	192.04
192.05	19205	ADULT DAY CARE	0	0	192.05
192.06	19206	PERSONAL TOUCH	0	0	192.06
192.07	19207	IV HEALTH CORP	0	0	192.07
192.08	19208	PUBLIC RELATIONS	0	357,030	192.08
192.09	19209	UTICA MEDICAL CENTER	0	0	192.09
192.10	19210	OGLESBY FAMILY MEDICINE	0	0	192.10
192.11	19211	FAST CARE	0	7	192.11
192.12	19212	IVCH CARE TODAY	0	0	192.12

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
192.13	19213	PPCC	0	0	192.13
192.14	19214	ADULT MEDICINE CLINIC	0	0	192.14
192.15	19215	PHYSICIANS PRIVATE OFFICES	0	0	192.15
192.16	19216	STREATOR MEDICAL CLINIC	0	480,421	192.16
192.17	19217	STREATOR ORTHO CLINIC	0	4,135	192.17
194.00	07950	OTHER PHYSICIANS OFFICES	0	252,215	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-15,495,586	66,593,091	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet Non-CMS Wo
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
43.00	NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
50.01	SAME DAY SURGERY	05001		50.01
50.02	LITHOTRIPSY	05002		50.02
50.03	ENDOSCOPY	05003		50.03
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
64.00	INTRAVENOUS THERAPY	06400		64.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
69.02	CARDIAC REHAB	06902		69.02
69.03	WOUND CARE	06903		69.03
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	08800		88.00
88.01	RURAL HEALTH CLINIC II	08801		88.01
88.02	RURAL HEALTH CLINIC III	08802		88.02
88.03	RURAL HEALTH CLINIC IV	08803		88.03
88.04	RURAL HEALTH CLINIC V	08804		88.04
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	09500		95.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
114.00	UTILIZATION REVIEW-SNF	11400		114.00
116.00	HOSPICE	11600		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT FLOWER COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS PRIVATE OFFICES	19200		192.00
192.01	MOB	19201		192.01
192.02	COMMUNITY HEALTH	19202		192.02
192.03	OCCUPATIONAL MEDICINE	19203		192.03
192.04	FAMILY PHARMACY	19204		192.04
192.05	ADULT DAY CARE	19205		192.05
192.06	PERSONAL TOUCH	19206		192.06
192.07	IV HEALTH CORP	19207		192.07
192.08	PUBLIC RELATIONS	19208		192.08
192.09	UTICA MEDICAL CENTER	19209		192.09
192.10	OGLESBY FAMILY MEDICINE	19210		192.10

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet Non-CMS Wo
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
192.11	FAST CARE	19211		192.11
192.12	IVCH CARE TODAY	19212		192.12
192.13	PPCC	19213		192.13
192.14	ADULT MEDICINE CLINIC	19214		192.14
192.15	PHYSICIANS PRIVATE OFFICES	19215		192.15
192.16	STREATOR MEDICAL CLINIC	19216		192.16
192.17	STREATOR ORTHO CLINIC	19217		192.17
194.00	OTHER PHYSICIANS OFFICES	07950		194.00
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-6

Date/Time Prepared:
1/28/2022 2:57 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	90,999		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	30,164		2.00
	0		0	121,163		
	B - CAFETERIA/MOW COSTS					
1.00	CAFETERIA	11.00	3,736	695,624		1.00
	0		3,736	695,624		
	C - RENTALS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,362,315		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	5,160		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
	0		0	1,367,475		
	D - IMPLANTABLE SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,693,963		1.00
	0		0	1,693,963		
	E - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	311,977		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
	0		0	311,977		
	F - HHA BLDG UTILITIES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	471		1.00
	0		0	471		
	G - RECLASS PMC MIDLEVEL SALARIES					
1.00	CLINIC	90.00	1,730	0		1.00
2.00	EMERGENCY	91.00	44,308	0		2.00
	TOTALS		46,038	0		
	H - NURSEY AND LABOR&DELIVERY					
1.00	NURSERY	43.00	356,047	58,019		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	347,299	56,589		2.00
	TOTALS		703,346	114,608		
500.00	Grand Total: Increases		753,120	4,305,281		500.00

RECLASSIFICATIONS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-6

Date/Time Prepared:
1/28/2022 2:57 pm

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
	A - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	121,163	12	1.00
2.00		0.00	0	0	12	2.00
	0		0	121,163		
	B - CAFETERIA/MOW COSTS					
1.00	DIETARY	10.00	3,736	695,624	0	1.00
	0		3,736	695,624		
	C - RENTALS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	41,426	10	1.00
2.00	OPERATION OF PLANT	7.00	0	4,910	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	275	0	3.00
4.00	PHARMACY	15.00	0	79,297	0	4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	773	0	5.00
6.00	OPERATING ROOM	50.00	0	453,016	0	6.00
7.00	ENDOSCOPY	50.03	0	129,745	0	7.00
8.00	ANESTHESIOLOGY	53.00	0	1,726	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	288,578	0	9.00
10.00	LABORATORY	60.00	0	1,427	0	10.00
11.00	RESPIRATORY THERAPY	65.00	0	40,145	0	11.00
12.00	PHYSICAL THERAPY	66.00	0	257,296	0	12.00
13.00	WOUND CARE	69.03	0	7,861	0	13.00
14.00	COMMUNITY HEALTH	192.02	0	12,300	0	14.00
15.00	STREATOR MEDICAL CLINIC	192.16	0	48,700	0	15.00
	0		0	1,367,475		
	D - IMPLANTABLE SUPPLIES					
1.00	OPERATING ROOM	50.00	0	1,693,963	0	1.00
	0		0	1,693,963		
	E - MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	161,970	0	1.00
2.00	RESPIRATORY THERAPY	65.00	0	56,212	0	2.00
3.00	PHYSICAL THERAPY	66.00	0	11,285	0	3.00
4.00	EMERGENCY	91.00	0	82,510	0	4.00
	0		0	311,977		
	F - HHA BLDG UTILITIES					
1.00	HOSPICE	116.00	0	471	0	1.00
	0		0	471		
	G - RECLASS PMC MIDLEVEL SALARIES					
1.00	RURAL HEALTH CLINIC III	88.02	46,038	0	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		46,038	0		
	H - NURSEY AND LABOR&DELIVERY					
1.00	ADULTS & PEDIATRICS	30.00	703,346	114,608	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		703,346	114,608		
500.00	Grand Total: Decreases		753,120	4,305,281		500.00

RECLASSIFICATIONS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
1/28/2022 2:57 pm

Increases					Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
A - PROPERTY INSURANCE									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	90,999	ADMINISTRATIVE & GENERAL	5.00	0	121,163	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	30,164		0.00	0	0	2.00
			0	121,163			0	121,163	
B - CAFETERIA/MOW COSTS									
1.00	CAFETERIA	11.00	3,736	695,624	DIETARY	10.00	3,736	695,624	1.00
			3,736	695,624			3,736	695,624	
C - RENTALS									
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,362,315	ADMINISTRATIVE & GENERAL	5.00	0	41,426	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	5,160	OPERATION OF PLANT	7.00	0	4,910	2.00
3.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	275	3.00
4.00		0.00	0	0	PHARMACY	15.00	0	79,297	4.00
5.00		0.00	0	0	MEDICAL RECORDS & LIBRARY	16.00	0	773	5.00
6.00		0.00	0	0	OPERATING ROOM	50.00	0	453,016	6.00
7.00		0.00	0	0	ENDOSCOPY	50.03	0	129,745	7.00
8.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	1,726	8.00
9.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	288,578	9.00
10.00		0.00	0	0	LABORATORY	60.00	0	1,427	10.00
11.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	40,145	11.00
12.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	257,296	12.00
13.00		0.00	0	0	WOUND CARE	69.03	0	7,861	13.00
14.00		0.00	0	0	COMMUNITY HEALTH	192.02	0	12,300	14.00
15.00		0.00	0	0	STREATOR MEDICAL CLINIC	192.16	0	48,700	15.00
			0	1,367,475			0	1,367,475	
D - IMPLANTABLE SUPPLIES									
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,693,963	OPERATING ROOM	50.00	0	1,693,963	1.00
			0	1,693,963			0	1,693,963	
E - MEDICAL SUPPLIES									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	311,977	CENTRAL SERVICES & SUPPLY	14.00	0	161,970	1.00
2.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	56,212	2.00
3.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	11,285	3.00
4.00		0.00	0	0	EMERGENCY	91.00	0	82,510	4.00
			0	311,977			0	311,977	
F - HHA BLDG UTILITIES									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	471	HOSPICE	116.00	0	471	1.00
			0	471			0	471	
G - RECLASS PMC MIDLEVEL SALARIES									
1.00	CLINIC	90.00	1,730	0	RURAL HEALTH CLINIC III	88.02	46,038	0	1.00
2.00	EMERGENCY	91.00	44,308	0		0.00	0	0	2.00
	TOTALS		46,038	0	TOTALS		46,038	0	
H - NURSEY AND LABOR&DELIVERY									
1.00	NURSERY	43.00	356,047	58,019	ADULTS & PEDIATRICS	30.00	703,346	114,608	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	347,299	56,589		0.00	0	0	2.00
	TOTALS		703,346	114,608	TOTALS		703,346	114,608	
500.00	Grand Total: Increases		753,120	4,305,281	Grand Total: Decreases		753,120	4,305,281	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
1/28/2022 2:57 pm

		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	1,476,235	0	0	0	0	1.00	
2.00	Land Improvements	1,356,820	0	0	0	0	2.00	
3.00	Buildings and Fixtures	53,824,166	20,618	0	20,618	0	3.00	
4.00	Building Improvements	325,067	0	0	0	0	4.00	
5.00	Fixed Equipment	14,479,381	54,302	0	54,302	0	5.00	
6.00	Movable Equipment	45,573,843	659,430	0	659,430	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	117,035,512	734,350	0	734,350	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	117,035,512	734,350	0	734,350	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,476,235	0				1.00	
2.00	Land Improvements	1,356,820	0				2.00	
3.00	Buildings and Fixtures	53,844,784	0				3.00	
4.00	Building Improvements	325,067	0				4.00	
5.00	Fixed Equipment	14,533,683	0				5.00	
6.00	Movable Equipment	46,233,273	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	117,769,862	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	117,769,862	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,093,976	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,280,466	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,374,442	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	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	1,093,976				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,280,466				2.00
3.00	Total (sum of lines 1-2)	0	2,374,442				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	71,461,669	0	71,461,669	0.610598	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	45,573,843	0	45,573,843	0.389402	0	2.00
3.00	Total (sum of lines 1-2)	117,035,512	0	117,035,512	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,093,976	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,271,372	1,362,315	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,365,348	1,362,315	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	90,999	0	0	1,184,975	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	30,164	0	0	2,663,851	2.00
3.00	Total (sum of lines 1-2)	0	121,163	0	0	3,848,826	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
1/28/2022 2:57 pm

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 #		
		1.00	2.00	3.00	4.00	5.00	
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)	B	-91,994	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-2,566	PHARMACY	15.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-39,661	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-7,098	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)	B	-5,307	OPERATION OF PLANT	7.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-10,242,753			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-875	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service	B	0	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	B	-66,529	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-955	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	UTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER REVENUE -OB	B	0	ADULTS & PEDIATRICS	30.00	0	33.00
33.01	PARKING GARAGE PARKING TAXES	A	-15,739	OPERATION OF PLANT	7.00	0	33.01
33.02	OTHER REVENUE - EDUCATION	B	-60	NURSING ADMINISTRATION	13.00	0	33.02

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
1/28/2022 2:57 pm

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 #		
		1.00	2.00	3.00	4.00	5.00	
33.03	PHYSICIAN BILLING 2110	A	-290,857	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	AHA/IHA LOBBYING	A	-22,477	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	POB EXP	A	0	CLINIC	90.00	0	33.05
33.06	NUTRITIONAL SUPPORT G/L 4095.02	B	-30,058	DIETARY	10.00	0	33.06
33.07	INTEREST EXPENSE	A	-639,602	INTEREST EXPENSE	113.00	9	33.07
33.08	PHYSICIAN RECRUITMENT	A	-316	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	MISCELLANEOUS REV G/L 5100.090	B	-4,321	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	TV OPERATING COSTS	A	-7,281	OPERATION OF PLANT	7.00	0	33.10
33.11	TV DEPR	A	-9,094	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.11
33.12	IVHS PHYSICIANS PMC	A	0	CLINIC	90.00	0	33.12
33.13	IVHS PHYSICIANS WHCC	A	0	CLINIC	90.00	0	33.13
33.14	IVHS PHYSICIANS LMC	A	0	CLINIC	90.00	0	33.14
33.15	PHO / IV ORTHO	A	0	CLINIC	90.00	0	33.15
33.16	OGLESBY FAMILY MEDICINE & PEDS	A	0	CLINIC	90.00	0	33.16
33.17	TRANSPORT VEHICLE REVENUE	B	-221,336	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	RENTAL INCOME - LAS PHY OFF	B	-30,804	RURAL HEALTH CLINIC II	88.01	0	33.18
33.19	RENTAL INCOME TO CLINIC - LAS PHY OF	B	0	CLINIC	90.00	0	33.19
33.20	RENTAL INCOME - IV ORTHO	B	-57,120	CLINIC	90.00	0	33.20
33.21	RENTAL INCOME DR. KIM	B	0	CLINIC	90.00	0	33.21
33.22	RENTAL INCOME - PMC	B	-17,160	RURAL HEALTH CLINIC III	88.02	0	33.22
33.23	RENTAL INCOME TO CLINIC - PMC	B	0	CLINIC	90.00	0	33.23
33.24	RENTAL INCOME - WHCC	B	-60,000	RURAL HEALTH CLINIC	88.00	0	33.24
33.25	RENTAL INCOME TO CLINIC- WHCC	B	0	CLINIC	90.00	0	33.25
33.26	RENTAL INCOME - ENT	B	-28,800	CLINIC	90.00	0	33.26
33.27	RENTAL INCOME - SLEEP CLINIC	B	-10,800	CLINIC	90.00	0	33.27
33.28	RENTAL INCOME - PPCC	B	-36,000	RURAL HEALTH CLINIC IV	88.03	0	33.28
33.29	RENTAL INCOME TO CLINIC - PPCC	B	0	CLINIC	90.00	0	33.29
33.30	RENTAL INCOME - OMC	B	-50,000	RURAL HEALTH CLINIC V	88.04	0	33.30
33.31	RENTAL INCOME TO CLINIC- OMC	B	0	CLINIC	90.00	0	33.31
33.32	MIDLEVEL SALARIES - EMERGENCY	B	0	EMERGENCY	91.00	0	33.32
33.33	MIDLEVEL SLARIES - CLINIC	B	0	CLINIC	90.00	0	33.33
33.34	HOSPITALIST	B	-98,767	ADULTS & PEDIATRICS	30.00	0	33.34
33.35	MANAGEMENT FEES	B	-60,000	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	NON-OP REV/EXP - VRHS	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.36
33.37	NON-OP REV/EXP - MISC REV/(EXP)	B	-9,552	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38	PROPERTY INS CLAIM PROCEEDS	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.38
33.39	MEDICAID ASSESSMENT	B	-3,066,033	ADMINISTRATIVE & GENERAL	5.00	0	33.39
33.40	CBO	B	-271,671	ADMINISTRATIVE & GENERAL	5.00	0	33.40
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,495,586				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: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-2

Date/Time Prepared:
1/28/2022 2:57 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,058,662	1,058,662	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	408,018	408,018	0	0	0	2.00
3.00	90.00	CLINIC	3,107,528	3,107,528	0	0	0	3.00
4.00	91.00	EMERGENCY	44,308	44,308	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	340,039	340,039	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	50,700	50,700	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	1,541,778	1,541,778	0	0	0	7.00
8.00	60.00	LABORATORY	9,634	9,634	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	-4,800	-4,800	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	115,830	115,830	0	0	0	10.00
11.00	70.00	ELECTROENCEPHALOGRAPHY	240	240	0	0	0	11.00
12.00	90.00	CLINIC	157,977	157,977	0	0	0	12.00
13.00	91.00	EMERGENCY	2,691,806	2,691,806	0	0	0	13.00
14.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	721,033	721,033	0	0	0	14.00
200.00			10,242,753	10,242,753	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	0	0	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	10.00
11.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	11.00
12.00	90.00	CLINIC	0	0	0	0	0	12.00
13.00	91.00	EMERGENCY	0	0	0	0	0	13.00
14.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	14.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,058,662		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	408,018		2.00
3.00	90.00	CLINIC	0	0	0	3,107,528		3.00
4.00	91.00	EMERGENCY	0	0	0	44,308		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	340,039		5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	50,700		6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	1,541,778		7.00
8.00	60.00	LABORATORY	0	0	0	9,634		8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	-4,800		9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	115,830		10.00
11.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	240		11.00
12.00	90.00	CLINIC	0	0	0	157,977		12.00
13.00	91.00	EMERGENCY	0	0	0	2,691,806		13.00
14.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	721,033		14.00
200.00			0	0	0	10,242,753		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,184,975	1,184,975			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,663,851		2,663,851		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,839,075	4,815	10,823	5,854,713	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,635,881	184,804	415,437	777,440	5.00
7.00	00700	OPERATION OF PLANT	2,879,583	180,466	405,692	141,725	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	190,569	20,546	46,188	0	8.00
9.00	00900	HOUSEKEEPING	1,435,496	13,820	31,067	1,537	9.00
10.00	01000	DIETARY	697,951	23,059	51,837	49,539	10.00
11.00	01100	CAFETERIA	632,831	13,463	30,266	864	11.00
13.00	01300	NURSING ADMINISTRATION	659,157	7,606	17,100	143,342	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	221,249	14,940	33,585	39,499	14.00
15.00	01500	PHARMACY	926,668	7,033	15,809	158,414	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	849,834	9,395	21,121	116,770	16.00
17.00	01700	SOCIAL SERVICE	195,619	2,407	5,412	43,102	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,095,914	173,294	389,570	630,215	30.00
31.00	03100	INTENSIVE CARE UNIT	995,531	19,208	43,181	141,989	31.00
43.00	04300	NURSERY	414,066	0	0	82,374	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,284,697	45,812	102,986	130,552	50.00
50.01	05001	SAME DAY SURGERY	448,166	17,347	38,997	95,670	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	437,422	0	0	52,966	50.03
51.00	05100	RECOVERY ROOM	224,503	4,820	10,836	50,404	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	403,888	0	0	80,344	52.00
53.00	05300	ANESTHESIOLOGY	415,100	11,903	26,758	46,316	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,364,469	44,731	100,556	306,037	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	3,283,230	19,392	43,595	213,940	60.00
64.00	06400	INTRAVENOUS THERAPY	150,158	22,452	50,472	32,064	64.00
65.00	06500	RESPIRATORY THERAPY	454,101	8,827	19,843	72,700	65.00
66.00	06600	PHYSICAL THERAPY	1,253,032	26,414	59,379	260,925	66.00
67.00	06700	OCCUPATIONAL THERAPY	140,446	0	0	31,479	67.00
68.00	06800	SPEECH PATHOLOGY	67,107	0	0	15,267	68.00
69.00	06900	ELECTROCARDIOLOGY	196,218	2,987	6,715	32,944	69.00
69.02	06902	CARDIAC REHAB	95,460	19,359	43,519	20,600	69.02
69.03	06903	WOUND CARE	1,043,708	0	0	149	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	89,071	451	1,015	19,196	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	311,977	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,693,963	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,490,891	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,478,478	40,752	91,611	421,619	88.00
88.01	08801	RURAL HEALTH CLINIC II	764,228	0	0	144,189	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,150,887	20,061	45,098	221,555	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,631,692	23,182	52,113	251,146	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,133,248	0	0	193,631	88.04
90.00	09000	CLINIC	2,409,598	50,286	113,045	225,941	90.00
91.00	09100	EMERGENCY	1,599,819	18,289	41,114	291,538	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	93,525	234	526	12,021	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	348,893	10,671	23,990	49,312	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	64,976,225	1,062,826	2,389,256	5,599,315	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	1,828	4,109	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	MOB	0	118,711	266,866	0	192.01
192.02	19202	COMMUNITY HEALTH	135,646	0	0	25,454	192.02
192.03	19203	OCCUPATIONAL MEDICINE	387,412	897	2,017	69,253	192.03
192.04	19204	FAMILY PHARMACY	0	0	0	0	192.04
192.05	19205	ADULT DAY CARE	0	0	0	0	192.05
192.06	19206	PERSONAL TOUCH	0	0	0	0	192.06
192.07	19207	IV HEALTH CORP	0	0	0	0	192.07
192.08	19208	PUBLIC RELATIONS	357,030	713	1,603	15,496	192.08

COST ALLOCATION - GENERAL SERVICE COSTS

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From 07/01/2020
To 06/30/2021Worksheet B
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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	
192.09	19209	UTICA MEDICAL CENTER	0	0	0	0	0	192.09
192.10	19210	OGLESBY FAMILY MEDICINE	0	0	0	0	0	192.10
192.11	19211	FAST CARE	7	0	0	0	7	192.11
192.12	19212	IVCH CARE TODAY	0	0	0	0	0	192.12
192.13	19213	PPCC	0	0	0	0	0	192.13
192.14	19214	ADULT MEDICINE CLINIC	0	0	0	0	0	192.14
192.15	19215	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.15
192.16	19216	STREATOR MEDICAL CLINIC	480,421	0	0	89,762	570,183	192.16
192.17	19217	STREATOR ORTHO CLINIC	4,135	0	0	0	4,135	192.17
194.00	07950	OTHER PHYSICIANS OFFICES	252,215	0	0	55,433	307,648	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	66,593,091	1,184,975	2,663,851	5,854,713	66,593,091	202.00

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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,013,562					5.00
7.00	00700	OPERATION OF PLANT	794,043	4,401,509				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	56,635	110,975	424,913			8.00
9.00	00900	HOUSEKEEPING	326,187	74,646	0	1,882,753		9.00
10.00	01000	DIETARY	181,016	124,550	0	46,518	1,174,470	10.00
11.00	01100	CAFETERIA	149,108	72,719	0	0	580,620	11.00
13.00	01300	NURSING ADMINISTRATION	182,077	41,085	0	8,307	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	68,074	80,696	1,926	38,627	0	14.00
15.00	01500	PHARMACY	243,866	37,985	0	13,291	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	219,477	50,747	0	9,968	0	16.00
17.00	01700	SOCIAL SERVICE	54,266	13,003	0	1,661	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	944,062	936,020	205,293	553,377	254,803	30.00
31.00	03100	INTENSIVE CARE UNIT	264,113	103,752	31,443	48,595	43,550	31.00
43.00	04300	NURSERY	109,272	0	1,683	43,057	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	784,486	247,445	44,186	212,656	0	50.00
50.01	05001	SAME DAY SURGERY	132,106	93,698	33,627	149,108	46,033	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	107,940	0	0	16,614	0	50.03
51.00	05100	RECOVERY ROOM	63,956	26,036	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	106,585	0	1,642	41,950	0	52.00
53.00	05300	ANESTHESIOLOGY	110,072	64,292	1,639	22,844	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	839,898	241,605	38,781	49,426	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	783,630	104,745	176	37,796	0	60.00
64.00	06400	INTRAVENOUS THERAPY	56,160	121,269	1,257	23,259	0	64.00
65.00	06500	RESPIRATORY THERAPY	122,265	47,677	2,964	26,582	0	65.00
66.00	06600	PHYSICAL THERAPY	352,123	142,670	0	11,630	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	37,843	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,131	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	52,577	16,133	3,434	12,876	0	69.00
69.02	06902	CARDIAC REHAB	39,386	104,564	0	22,013	0	69.02
69.03	06903	WOUND CARE	229,764	0	1,329	47,765	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	24,153	2,438	0	8,307	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	68,670	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	372,860	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	548,273	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	667,478	220,115	5,960	80,992	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	199,953	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	316,432	108,357	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	431,007	125,212	0	49,841	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	292,061	0	0	0	0	88.04
90.00	09000	CLINIC	616,062	271,614	0	152,016	0	90.00
91.00	09100	EMERGENCY	429,384	98,785	38,733	83,069	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	23,399	1,264	10,684	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	95,279	57,640	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,514,129	3,741,737	424,757	1,812,145	925,006	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,307	9,872	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MOB	84,870	641,201	0	0	0	192.01
192.02	19202	COMMUNITY HEALTH	35,460	0	0	1,661	0	192.02
192.03	19203	OCCUPATIONAL MEDICINE	101,158	4,846	0	27,413	0	192.03
192.04	19204	FAMILY PHARMACY	0	0	0	0	0	192.04
192.05	19205	ADULT DAY CARE	0	0	0	0	0	192.05
192.06	19206	PERSONAL TOUCH	0	0	0	0	0	192.06
192.07	19207	IV HEALTH CORP	0	0	0	0	0	192.07
192.08	19208	PUBLIC RELATIONS	82,507	3,853	0	0	0	192.08
192.09	19209	UTICA MEDICAL CENTER	0	0	0	0	0	192.09
192.10	19210	OGLESBY FAMILY MEDICINE	0	0	0	0	0	192.10
192.11	19211	FAST CARE	0	0	0	0	0	192.11
192.12	19212	IVCH CARE TODAY	0	0	0	0	0	192.12
192.13	19213	PPCC	0	0	0	0	0	192.13

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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
192.14	19214	ADULT MEDICINE CLINIC	0	0	0	0	0	192.14
192.15	19215	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.15
192.16	19216	STREATOR MEDICAL CLINIC	125,504	0	0	0	0	192.16
192.17	19217	STREATOR ORTHO CLINIC	910	0	0	0	0	192.17
194.00	07950	OTHER PHYSICIANS OFFICES	67,717	0	156	41,534	249,464	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	12,013,562	4,401,509	424,913	1,882,753	1,174,470	202.00

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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,479,871					11.00
13.00	01300	NURSING ADMINISTRATION	33,155	1,091,829				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,574	0	518,170			14.00
15.00	01500	PHARMACY	37,165	0	0	1,440,231		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	59,240	0	0	0	1,336,552	16.00
17.00	01700	SOCIAL SERVICE	13,409	21,104	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	254,850	401,453	0	0	60,225	30.00
31.00	03100	INTENSIVE CARE UNIT	45,917	72,365	0	0	21,792	31.00
43.00	04300	NURSERY	30,137	47,502	0	0	6,019	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	44,581	71,242	0	0	173,039	50.00
50.01	05001	SAME DAY SURGERY	33,285	52,420	0	0	12,411	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	22,420	35,342	0	0	25,549	50.03
51.00	05100	RECOVERY ROOM	14,616	23,047	0	0	19,439	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,404	46,330	0	0	6,171	52.00
53.00	05300	ANESTHESIOLOGY	23,454	36,935	0	0	34,181	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,638	0	0	0	303,925	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	87,178	0	0	0	227,440	60.00
64.00	06400	INTRAVENOUS THERAPY	9,183	14,489	0	0	5,001	64.00
65.00	06500	RESPIRATORY THERAPY	23,799	0	0	0	9,159	65.00
66.00	06600	PHYSICAL THERAPY	84,074	132,436	0	0	31,735	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,330	0	0	0	3,649	67.00
68.00	06800	SPEECH PATHOLOGY	4,872	0	0	0	2,799	68.00
69.00	06900	ELECTROCARDIOLOGY	19,747	0	0	0	25,159	69.00
69.02	06902	CARDIAC REHAB	5,174	0	0	0	2,804	69.02
69.03	06903	WOUND CARE	43	0	0	0	25,907	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	5,562	0	0	0	4,108	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	80,589	0	11,065	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	437,581	0	30,964	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,431,208	104,744	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	88,903	0	0	0	24,976	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	5,975	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	9,694	88.02
88.03	08803	RURAL HEALTH CLINIC IV	54,885	0	0	0	15,489	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	9,956	88.04
90.00	09000	CLINIC	166,725	0	0	0	38,684	90.00
91.00	09100	EMERGENCY	87,049	137,164	0	0	80,689	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	4,656	0	0	0	65	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	9,023	3,739	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,410,025	1,091,829	518,170	1,440,231	1,336,552	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MOB	0	0	0	0	0	192.01
192.02	19202	COMMUNITY HEALTH	3,837	0	0	0	0	192.02
192.03	19203	OCCUPATIONAL MEDICINE	21,989	0	0	0	0	192.03
192.04	19204	FAMILY PHARMACY	0	0	0	0	0	192.04
192.05	19205	ADULT DAY CARE	0	0	0	0	0	192.05
192.06	19206	PERSONAL TOUCH	0	0	0	0	0	192.06
192.07	19207	IV HEALTH CORP	0	0	0	0	0	192.07
192.08	19208	PUBLIC RELATIONS	4,656	0	0	0	0	192.08
192.09	19209	UTICA MEDICAL CENTER	0	0	0	0	0	192.09
192.10	19210	OGLESBY FAMILY MEDICINE	0	0	0	0	0	192.10
192.11	19211	FAST CARE	0	0	0	0	0	192.11
192.12	19212	IVCH CARE TODAY	0	0	0	0	0	192.12

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
192.13	19213	PPCC	0	0	0	0	0	192.13
192.14	19214	ADULT MEDICINE CLINIC	0	0	0	0	0	192.14
192.15	19215	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.15
192.16	19216	STREATOR MEDICAL CLINIC	21,730	0	0	0	0	192.16
192.17	19217	STREATOR ORTHO CLINIC	0	0	0	0	0	192.17
194.00	07950	OTHER PHYSICIANS OFFICES	17,634	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,479,871	1,091,829	518,170	1,440,231	1,336,552	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	349,983				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	291,854	8,190,930	0	8,190,930	30.00
31.00	03100	INTENSIVE CARE UNIT	58,129	1,889,565	0	1,889,565	31.00
43.00	04300	NURSERY	0	734,110	0	734,110	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	5,141,682	0	5,141,682	50.00
50.01	05001	SAME DAY SURGERY	0	1,152,868	0	1,152,868	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	0	698,253	0	698,253	50.03
51.00	05100	RECOVERY ROOM	0	437,657	0	437,657	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	716,314	0	716,314	52.00
53.00	05300	ANESTHESIOLOGY	0	793,494	0	793,494	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,389,066	0	5,389,066	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	4,801,122	0	4,801,122	60.00
64.00	06400	INTRAVENOUS THERAPY	0	485,764	0	485,764	64.00
65.00	06500	RESPIRATORY THERAPY	0	787,917	0	787,917	65.00
66.00	06600	PHYSICAL THERAPY	0	2,354,418	0	2,354,418	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	220,747	0	220,747	67.00
68.00	06800	SPEECH PATHOLOGY	0	108,176	0	108,176	68.00
69.00	06900	ELECTROCARDIOLOGY	0	368,790	0	368,790	69.00
69.02	06902	CARDIAC REHAB	0	352,879	0	352,879	69.02
69.03	06903	WOUND CARE	0	1,348,665	0	1,348,665	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	154,301	0	154,301	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	472,301	0	472,301	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,535,368	0	2,535,368	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,575,116	0	4,575,116	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	4,120,884	0	4,120,884	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,114,345	0	1,114,345	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,872,084	0	1,872,084	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	2,634,567	0	2,634,567	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,628,896	0	1,628,896	88.04
90.00	09000	CLINIC	0	4,043,971	0	4,043,971	90.00
91.00	09100	EMERGENCY	0	2,905,633	0	2,905,633	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	146,374	0	146,374	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	598,547	0	598,547	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	349,983	62,774,804	0	62,774,804	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	17,116	0	17,116	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	MOB	0	1,111,648	0	1,111,648	192.01
192.02	19202	COMMUNITY HEALTH	0	202,058	0	202,058	192.02
192.03	19203	OCCUPATIONAL MEDICINE	0	614,985	0	614,985	192.03
192.04	19204	FAMILY PHARMACY	0	0	0	0	192.04
192.05	19205	ADULT DAY CARE	0	0	0	0	192.05
192.06	19206	PERSONAL TOUCH	0	0	0	0	192.06
192.07	19207	IV HEALTH CORP	0	0	0	0	192.07
192.08	19208	PUBLIC RELATIONS	0	465,858	0	465,858	192.08
192.09	19209	UTICA MEDICAL CENTER	0	0	0	0	192.09
192.10	19210	OGLESBY FAMILY MEDICINE	0	0	0	0	192.10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet B
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Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
192.11	19211	FAST CARE	0	7	0	7		192.11
192.12	19212	IVCH CARE TODAY	0	0	0	0		192.12
192.13	19213	PPCC	0	0	0	0		192.13
192.14	19214	ADULT MEDICINE CLINIC	0	0	0	0		192.14
192.15	19215	PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.15
192.16	19216	STREATOR MEDICAL CLINIC	0	717,417	0	717,417		192.16
192.17	19217	STREATOR ORTHO CLINIC	0	5,045	0	5,045		192.17
194.00	07950	OTHER PHYSICIANS OFFICES	0	684,153	0	684,153		194.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	349,983	66,593,091	0	66,593,091		202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet Non-CMS Wo
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	6	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	7	HOURS OF SERVICE	9.00
10.00	DIETARY	8	MEALS SERVED	10.00
11.00	CAFETERIA	9	FTES	11.00
13.00	NURSING ADMINISTRATION	11	DIRECT NRSING HRS	13.00
14.00	CENTRAL SERVICES & SUPPLY	12	COSTED REQUIS.	14.00
15.00	PHARMACY	13	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	14	GROSS CHAR GES	16.00
17.00	SOCIAL SERVICE	15	TOTAL PATI ENT DAYS	17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,815	10,823	15,638	15,638	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	184,804	415,437	600,241	2,073	5.00
7.00	00700	OPERATION OF PLANT	0	180,466	405,692	586,158	379	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,546	46,188	66,734	0	8.00
9.00	00900	HOUSEKEEPING	0	13,820	31,067	44,887	4	9.00
10.00	01000	DIETARY	0	23,059	51,837	74,896	132	10.00
11.00	01100	CAFETERIA	0	13,463	30,266	43,729	2	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,606	17,100	24,706	383	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,940	33,585	48,525	106	14.00
15.00	01500	PHARMACY	0	7,033	15,809	22,842	423	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,395	21,121	30,516	312	16.00
17.00	01700	SOCIAL SERVICE	0	2,407	5,412	7,819	115	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	173,294	389,570	562,864	1,684	30.00
31.00	03100	INTENSIVE CARE UNIT	0	19,208	43,181	62,389	379	31.00
43.00	04300	NURSERY	0	0	0	0	220	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	45,812	102,986	148,798	349	50.00
50.01	05001	SAME DAY SURGERY	0	17,347	38,997	56,344	256	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	0	0	0	0	141	50.03
51.00	05100	RECOVERY ROOM	0	4,820	10,836	15,656	135	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	215	52.00
53.00	05300	ANESTHESIOLOGY	0	11,903	26,758	38,661	124	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,731	100,556	145,287	818	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	19,392	43,595	62,987	572	60.00
64.00	06400	INTRAVENOUS THERAPY	0	22,452	50,472	72,924	86	64.00
65.00	06500	RESPIRATORY THERAPY	0	8,827	19,843	28,670	194	65.00
66.00	06600	PHYSICAL THERAPY	0	26,414	59,379	85,793	697	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	84	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	41	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,987	6,715	9,702	88	69.00
69.02	06902	CARDIAC REHAB	0	19,359	43,519	62,878	55	69.02
69.03	06903	WOUND CARE	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	451	1,015	1,466	51	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	40,752	91,611	132,363	1,126	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	385	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	20,061	45,098	65,159	592	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	23,182	52,113	75,295	671	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	517	88.04
90.00	09000	CLINIC	0	50,286	113,045	163,331	604	90.00
91.00	09100	EMERGENCY	0	18,289	41,114	59,403	779	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	234	526	760	32	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	10,671	23,990	34,661	132	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,062,826	2,389,256	3,452,082	14,956	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	1,828	4,109	5,937	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MOB	0	118,711	266,866	385,577	0	192.01
192.02	19202	COMMUNITY HEALTH	0	0	0	0	68	192.02
192.03	19203	OCCUPATIONAL MEDICINE	0	897	2,017	2,914	185	192.03
192.04	19204	FAMILY PHARMACY	0	0	0	0	0	192.04
192.05	19205	ADULT DAY CARE	0	0	0	0	0	192.05
192.06	19206	PERSONAL TOUCH	0	0	0	0	0	192.06
192.07	19207	IV HEALTH CORP	0	0	0	0	0	192.07
192.08	19208	PUBLIC RELATIONS	0	713	1,603	2,316	41	192.08
192.09	19209	UTICA MEDICAL CENTER	0	0	0	0	0	192.09

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
192.10	19210	OGLESBY FAMILY MEDICINE	0	0	0	0	0	192.10
192.11	19211	FAST CARE	0	0	0	0	0	192.11
192.12	19212	IVCH CARE TODAY	0	0	0	0	0	192.12
192.13	19213	PPCC	0	0	0	0	0	192.13
192.14	19214	ADULT MEDICINE CLINIC	0	0	0	0	0	192.14
192.15	19215	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.15
192.16	19216	STREATOR MEDICAL CLINIC	0	0	0	0	240	192.16
192.17	19217	STREATOR ORTHO CLINIC	0	0	0	0	0	192.17
194.00	07950	OTHER PHYSICIANS OFFICES	0	0	0	0	148	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,184,975	2,663,851	3,848,826	15,638	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	602,314					5.00
7.00	00700	OPERATION OF PLANT	39,812	626,349				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,840	15,792	85,366			8.00
9.00	00900	HOUSEKEEPING	16,354	10,622	0	71,867		9.00
10.00	01000	DIETARY	9,076	17,724	0	1,776	103,604	10.00
11.00	01100	CAFETERIA	7,476	10,348	0	0	51,218	11.00
13.00	01300	NURSING ADMINISTRATION	9,129	5,847	0	317	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,413	11,483	387	1,474	0	14.00
15.00	01500	PHARMACY	12,227	5,405	0	507	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,004	7,221	0	381	0	16.00
17.00	01700	SOCIAL SERVICE	2,721	1,850	0	63	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	47,307	133,199	41,245	21,123	22,477	30.00
31.00	03100	INTENSIVE CARE UNIT	13,242	14,764	6,317	1,855	3,842	31.00
43.00	04300	NURSERY	5,479	0	338	1,644	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	39,333	35,212	8,877	8,117	0	50.00
50.01	05001	SAME DAY SURGERY	6,624	13,334	6,756	5,692	4,061	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	5,412	0	0	634	0	50.03
51.00	05100	RECOVERY ROOM	3,207	3,705	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,344	0	330	1,601	0	52.00
53.00	05300	ANESTHESIOLOGY	5,519	9,149	329	872	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,111	34,381	7,791	1,887	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	39,290	14,906	35	1,443	0	60.00
64.00	06400	INTRAVENOUS THERAPY	2,816	17,257	252	888	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,130	6,785	596	1,015	0	65.00
66.00	06600	PHYSICAL THERAPY	17,655	20,302	0	444	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,897	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	909	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,636	2,296	690	491	0	69.00
69.02	06902	CARDIAC REHAB	1,975	14,880	0	840	0	69.02
69.03	06903	WOUND CARE	11,520	0	267	1,823	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	1,211	347	0	317	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,443	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,695	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,489	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	33,466	31,323	1,197	3,092	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	10,025	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	15,865	15,420	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	21,610	17,818	0	1,903	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	14,643	0	0	0	0	88.04
90.00	09000	CLINIC	30,888	38,652	0	5,803	0	90.00
91.00	09100	EMERGENCY	21,529	14,057	7,782	3,171	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,173	180	2,146	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	4,777	8,202	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	577,272	532,461	85,335	69,173	81,598	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	66	1,405	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MOB	4,255	91,245	0	0	0	192.01
192.02	19202	COMMUNITY HEALTH	1,778	0	0	63	0	192.02
192.03	19203	OCCUPATIONAL MEDICINE	5,072	690	0	1,046	0	192.03
192.04	19204	FAMILY PHARMACY	0	0	0	0	0	192.04
192.05	19205	ADULT DAY CARE	0	0	0	0	0	192.05
192.06	19206	PERSONAL TOUCH	0	0	0	0	0	192.06
192.07	19207	IV HEALTH CORP	0	0	0	0	0	192.07
192.08	19208	PUBLIC RELATIONS	4,137	548	0	0	0	192.08
192.09	19209	UTICA MEDICAL CENTER	0	0	0	0	0	192.09
192.10	19210	OGLESBY FAMILY MEDICINE	0	0	0	0	0	192.10
192.11	19211	FAST CARE	0	0	0	0	0	192.11
192.12	19212	IVCH CARE TODAY	0	0	0	0	0	192.12
192.13	19213	PPCC	0	0	0	0	0	192.13

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
192.14	19214	ADULT MEDICINE CLINIC	0	0	0	0	0	192.14
192.15	19215	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.15
192.16	19216	STREATOR MEDICAL CLINIC	6,293	0	0	0	0	192.16
192.17	19217	STREATOR ORTHO CLINIC	46	0	0	0	0	192.17
194.00	07950	OTHER PHYSICIANS OFFICES	3,395	0	31	1,585	22,006	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	602,314	626,349	85,366	71,867	103,604	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	112,773				11.00
13.00	01300	NURSING ADMINISTRATION	2,527	42,909			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,492	0	66,880		14.00
15.00	01500	PHARMACY	2,832	0	0	44,236	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,514	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,022	829	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	19,420	15,776	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,499	2,844	0	0	31.00
43.00	04300	NURSERY	2,297	1,867	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,397	2,800	0	0	50.00
50.01	05001	SAME DAY SURGERY	2,536	2,060	0	0	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	1,708	1,389	0	0	50.03
51.00	05100	RECOVERY ROOM	1,114	906	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,241	1,821	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,787	1,452	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,593	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	6,643	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	700	569	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,814	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	6,407	5,205	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	559	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	371	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,505	0	0	0	69.00
69.02	06902	CARDIAC REHAB	394	0	0	0	69.02
69.03	06903	WOUND CARE	3	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	424	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	10,402	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	56,478	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	43,959	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	6,775	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	4,182	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	88.04
90.00	09000	CLINIC	12,705	0	0	0	90.00
91.00	09100	EMERGENCY	6,634	5,391	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	355	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	0	0	277	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	107,450	42,909	66,880	44,236	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	MOB	0	0	0	0	192.01
192.02	19202	COMMUNITY HEALTH	292	0	0	0	192.02
192.03	19203	OCCUPATIONAL MEDICINE	1,676	0	0	0	192.03
192.04	19204	FAMILY PHARMACY	0	0	0	0	192.04
192.05	19205	ADULT DAY CARE	0	0	0	0	192.05
192.06	19206	PERSONAL TOUCH	0	0	0	0	192.06
192.07	19207	IV HEALTH CORP	0	0	0	0	192.07
192.08	19208	PUBLIC RELATIONS	355	0	0	0	192.08
192.09	19209	UTICA MEDICAL CENTER	0	0	0	0	192.09
192.10	19210	OGLESBY FAMILY MEDICINE	0	0	0	0	192.10
192.11	19211	FAST CARE	0	0	0	0	192.11
192.12	19212	IVCH CARE TODAY	0	0	0	0	192.12

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0234

 Period:
 From 07/01/2020
 To 06/30/2021

 Worksheet B
 Part II
 Date/Time Prepared:
 1/28/2022 2:57 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
192.13	19213	PPCC	0	0	0	0	0	192.13
192.14	19214	ADULT MEDICINE CLINIC	0	0	0	0	0	192.14
192.15	19215	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.15
192.16	19216	STREATOR MEDICAL CLINIC	1,656	0	0	0	0	192.16
192.17	19217	STREATOR ORTHO CLINIC	0	0	0	0	0	192.17
194.00	07950	OTHER PHYSICIANS OFFICES	1,344	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	112,773	42,909	66,880	44,236	53,948	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	14,419				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,024	879,551	0	879,551	30.00
31.00	03100	INTENSIVE CARE UNIT	2,395	112,406	0	112,406	31.00
43.00	04300	NURSERY	0	12,088	0	12,088	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	253,869	0	253,869	50.00
50.01	05001	SAME DAY SURGERY	0	98,164	0	98,164	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	0	10,316	0	10,316	50.03
51.00	05100	RECOVERY ROOM	0	25,508	0	25,508	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11,801	0	11,801	52.00
53.00	05300	ANESTHESIOLOGY	0	59,273	0	59,273	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	252,124	0	252,124	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	135,059	0	135,059	60.00
64.00	06400	INTRAVENOUS THERAPY	0	95,694	0	95,694	64.00
65.00	06500	RESPIRATORY THERAPY	0	45,574	0	45,574	65.00
66.00	06600	PHYSICAL THERAPY	0	137,784	0	137,784	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,687	0	2,687	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,434	0	1,434	68.00
69.00	06900	ELECTROCARDIOLOGY	0	18,424	0	18,424	69.00
69.02	06902	CARDIAC REHAB	0	81,135	0	81,135	69.02
69.03	06903	WOUND CARE	0	14,659	0	14,659	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,982	0	3,982	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,292	0	14,292	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	76,423	0	76,423	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	75,677	0	75,677	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	210,350	0	210,350	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	10,651	0	10,651	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	97,427	0	97,427	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	122,104	0	122,104	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	15,562	0	15,562	88.04
90.00	09000	CLINIC	0	253,545	0	253,545	90.00
91.00	09100	EMERGENCY	0	122,004	0	122,004	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	4,649	0	4,649	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	48,200	0	48,200	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,419	3,302,416	0	3,302,416	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	7,408	0	7,408	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	MOB	0	481,077	0	481,077	192.01
192.02	19202	COMMUNITY HEALTH	0	2,201	0	2,201	192.02
192.03	19203	OCCUPATIONAL MEDICINE	0	11,583	0	11,583	192.03
192.04	19204	FAMILY PHARMACY	0	0	0	0	192.04
192.05	19205	ADULT DAY CARE	0	0	0	0	192.05
192.06	19206	PERSONAL TOUCH	0	0	0	0	192.06
192.07	19207	IV HEALTH CORP	0	0	0	0	192.07
192.08	19208	PUBLIC RELATIONS	0	7,397	0	7,397	192.08
192.09	19209	UTICA MEDICAL CENTER	0	0	0	0	192.09
192.10	19210	OGLESBY FAMILY MEDICINE	0	0	0	0	192.10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
192.11	19211	FAST CARE	0	0	0	0		192.11
192.12	19212	IVCH CARE TODAY	0	0	0	0		192.12
192.13	19213	PPCC	0	0	0	0		192.13
192.14	19214	ADULT MEDICINE CLINIC	0	0	0	0		192.14
192.15	19215	PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.15
192.16	19216	STREATOR MEDICAL CLINIC	0	8,189	0	8,189		192.16
192.17	19217	STREATOR ORTHO CLINIC	0	46	0	46		192.17
194.00	07950	OTHER PHYSICIANS OFFICES	0	28,509	0	28,509		194.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	14,419	3,848,826	0	3,848,826		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	212,646					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		212,646				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	864	864	25,307,930			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	33,163	33,163	3,360,607	-12,013,562	54,579,522	5.00
7.00	00700	OPERATION OF PLANT	32,385	32,385	612,630	0	3,607,466	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,687	3,687	0	0	257,303	8.00
9.00	00900	HOUSEKEEPING	2,480	2,480	6,642	0	1,481,920	9.00
10.00	01000	DIETARY	4,138	4,138	214,139	0	822,386	10.00
11.00	01100	CAFETERIA	2,416	2,416	3,736	0	677,424	11.00
13.00	01300	NURSING ADMINISTRATION	1,365	1,365	619,618	0	827,205	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,681	2,681	170,742	0	309,273	14.00
15.00	01500	PHARMACY	1,262	1,262	684,768	0	1,107,924	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,686	1,686	504,758	0	997,120	16.00
17.00	01700	SOCIAL SERVICE	432	432	186,314	0	246,540	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,098	31,098	2,724,205	0	4,288,993	30.00
31.00	03100	INTENSIVE CARE UNIT	3,447	3,447	613,770	0	1,199,909	31.00
43.00	04300	NURSERY	0	0	356,074	0	496,440	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,221	8,221	564,332	0	3,564,047	50.00
50.01	05001	SAME DAY SURGERY	3,113	3,113	413,551	0	600,180	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	0	0	228,952	0	490,388	50.03
51.00	05100	RECOVERY ROOM	865	865	217,881	0	290,563	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	347,299	0	484,232	52.00
53.00	05300	ANESTHESIOLOGY	2,136	2,136	200,209	0	500,077	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,027	8,027	1,322,894	0	3,815,793	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,480	3,480	924,791	0	3,560,157	60.00
64.00	06400	INTRAVENOUS THERAPY	4,029	4,029	138,601	0	255,146	64.00
65.00	06500	RESPIRATORY THERAPY	1,584	1,584	314,257	0	555,471	65.00
66.00	06600	PHYSICAL THERAPY	4,740	4,740	1,127,890	0	1,599,750	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	136,072	0	171,925	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	65,996	0	82,374	68.00
69.00	06900	ELECTROCARDIOLOGY	536	536	142,404	0	238,864	69.00
69.02	06902	CARDIAC REHAB	3,474	3,474	89,045	0	178,938	69.02
69.03	06903	WOUND CARE	0	0	643	0	1,043,857	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	81	81	82,979	0	109,733	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	311,977	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,693,963	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,490,891	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	7,313	7,313	1,822,518	0	3,032,460	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	623,281	0	908,417	88.01
88.02	08802	RURAL HEALTH CLINIC III	3,600	3,600	957,707	0	1,437,601	88.02
88.03	08803	RURAL HEALTH CLINIC IV	4,160	4,160	1,085,617	0	1,958,133	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	837,000	0	1,326,879	88.04
90.00	09000	CLINIC	9,024	9,024	976,666	0	2,798,870	90.00
91.00	09100	EMERGENCY	3,282	3,282	1,260,221	0	1,950,760	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	42	42	51,961	0	106,306	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,915	1,915	213,157	0	432,866	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	190,726	190,726	24,203,927	-12,013,562	52,310,521	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	328	328	0	0	5,937	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MOB	21,303	21,303	0	0	385,577	192.01
192.02	19202	COMMUNITY HEALTH	0	0	110,031	0	161,100	192.02
192.03	19203	OCCUPATIONAL MEDICINE	161	161	299,359	0	459,579	192.03
192.04	19204	FAMILY PHARMACY	0	0	0	0	0	192.04
192.05	19205	ADULT DAY CARE	0	0	0	0	0	192.05
192.06	19206	PERSONAL TOUCH	0	0	0	0	0	192.06
192.07	19207	IV HEALTH CORP	0	0	0	0	0	192.07
192.08	19208	PUBLIC RELATIONS	128	128	66,986	0	374,842	192.08

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
192.09	19209	UTICA MEDICAL CENTER	0	0	0	0	0	192.09
192.10	19210	OGLESBY FAMILY MEDICINE	0	0	0	0	0	192.10
192.11	19211	FAST CARE	0	0	0	-7	0	192.11
192.12	19212	IVCH CARE TODAY	0	0	0	0	0	192.12
192.13	19213	PPCC	0	0	0	0	0	192.13
192.14	19214	ADULT MEDICINE CLINIC	0	0	0	0	0	192.14
192.15	19215	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.15
192.16	19216	STREATOR MEDICAL CLINIC	0	0	388,010	0	570,183	192.16
192.17	19217	STREATOR ORTHO CLINIC	0	0	0	0	4,135	192.17
194.00	07950	OTHER PHYSICIANS OFFICES	0	0	239,617	0	307,648	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,184,975	2,663,851	5,854,713		12,013,562	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.572524	12.527163	0.231339		0.220111	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			15,638		602,314	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000618		0.011036	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	146,234				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,687	275,925			8.00
9.00	00900	HOUSEKEEPING	2,480	0	13,599		9.00
10.00	01000	DIETARY	4,138	0	336	88,430	10.00
11.00	01100	CAFETERIA	2,416	0	0	43,717	11.00
13.00	01300	NURSING ADMINISTRATION	1,365	0	60	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,681	1,251	279	0	14.00
15.00	01500	PHARMACY	1,262	0	96	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,686	0	72	0	16.00
17.00	01700	SOCIAL SERVICE	432	0	12	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	31,098	133,312	3,997	19,185	30.00
31.00	03100	INTENSIVE CARE UNIT	3,447	20,418	351	3,279	31.00
43.00	04300	NURSERY	0	1,093	311	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,221	28,693	1,536	0	50.00
50.01	05001	SAME DAY SURGERY	3,113	21,836	1,077	3,466	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	0	0	120	0	50.03
51.00	05100	RECOVERY ROOM	865	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,066	303	0	52.00
53.00	05300	ANESTHESIOLOGY	2,136	1,064	165	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,027	25,183	357	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	3,480	114	273	0	60.00
64.00	06400	INTRAVENOUS THERAPY	4,029	816	168	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,584	1,925	192	0	65.00
66.00	06600	PHYSICAL THERAPY	4,740	0	84	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	536	2,230	93	0	69.00
69.02	06902	CARDIAC REHAB	3,474	0	159	0	69.02
69.03	06903	WOUND CARE	0	863	345	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	81	0	60	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	7,313	3,870	585	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	3,600	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	4,160	0	360	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	88.04
90.00	09000	CLINIC	9,024	0	1,098	0	90.00
91.00	09100	EMERGENCY	3,282	25,152	600	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	42	6,938	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	1,915	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	124,314	275,824	13,089	69,647	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	328	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	MOB	21,303	0	0	0	192.01
192.02	19202	COMMUNITY HEALTH	0	0	12	0	192.02
192.03	19203	OCCUPATIONAL MEDICINE	161	0	198	0	192.03
192.04	19204	FAMILY PHARMACY	0	0	0	0	192.04
192.05	19205	ADULT DAY CARE	0	0	0	0	192.05
192.06	19206	PERSONAL TOUCH	0	0	0	0	192.06
192.07	19207	IV HEALTH CORP	0	0	0	0	192.07
192.08	19208	PUBLIC RELATIONS	128	0	0	0	192.08
192.09	19209	UTICA MEDICAL CENTER	0	0	0	0	192.09
192.10	19210	OGLESBY FAMILY MEDICINE	0	0	0	0	192.10
192.11	19211	FAST CARE	0	0	0	0	192.11

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
192.12	19212	IVCH CARE TODAY	0	0	0	0	0	192.12
192.13	19213	PPCC	0	0	0	0	0	192.13
192.14	19214	ADULT MEDICINE CLINIC	0	0	0	0	0	192.14
192.15	19215	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.15
192.16	19216	STREATOR MEDICAL CLINIC	0	0	0	0	504	192.16
192.17	19217	STREATOR ORTHO CLINIC	0	0	0	0	0	192.17
194.00	07950	OTHER PHYSICIANS OFFICES	0	101	300	18,783	409	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,401,509	424,913	1,882,753	1,174,470	1,479,871	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.099081	1.539958	138.447901	13.281352	43.114759	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	626,349	85,366	71,867	103,604	112,773	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.283197	0.309381	5.284727	1.171593	3.285544	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	334,360					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,005,940				14.00
15.00	01500	PHARMACY	0	0	2,506,594			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	219,352,338		16.00
17.00	01700	SOCIAL SERVICE	6,463	0	0	0	5,202	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	122,940	0	0	9,884,336	4,338	30.00
31.00	03100	INTENSIVE CARE UNIT	22,161	0	0	3,576,487	864	31.00
43.00	04300	NURSERY	14,547	0	0	987,780	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,817	0	0	28,399,683	0	50.00
50.01	05001	SAME DAY SURGERY	16,053	0	0	2,036,945	0	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	10,823	0	0	4,193,248	0	50.03
51.00	05100	RECOVERY ROOM	7,058	0	0	3,190,336	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,188	0	0	1,012,737	0	52.00
53.00	05300	ANESTHESIOLOGY	11,311	0	0	5,609,952	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	49,874,923	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	37,328,048	0	60.00
64.00	06400	INTRAVENOUS THERAPY	4,437	0	0	820,739	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,503,183	0	65.00
66.00	06600	PHYSICAL THERAPY	40,557	0	0	5,208,458	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	598,954	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	459,309	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,129,094	0	69.00
69.02	06902	CARDIAC REHAB	0	0	0	460,193	0	69.02
69.03	06903	WOUND CARE	0	0	0	4,251,990	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	674,160	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	311,977	0	1,816,035	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,693,963	0	5,081,889	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,490,891	17,190,907	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,099,107	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	980,582	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,590,925	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	2,542,109	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	1,634,076	0	88.04
90.00	09000	CLINIC	0	0	0	6,348,938	0	90.00
91.00	09100	EMERGENCY	42,005	0	0	13,242,847	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	10,750	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	15,703	613,618	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	334,360	2,005,940	2,506,594	219,352,338	5,202	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MOB	0	0	0	0	0	192.01
192.02	19202	COMMUNITY HEALTH	0	0	0	0	0	192.02
192.03	19203	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.03
192.04	19204	FAMILY PHARMACY	0	0	0	0	0	192.04
192.05	19205	ADULT DAY CARE	0	0	0	0	0	192.05
192.06	19206	PERSONAL TOUCH	0	0	0	0	0	192.06
192.07	19207	IV HEALTH CORP	0	0	0	0	0	192.07
192.08	19208	PUBLIC RELATIONS	0	0	0	0	0	192.08
192.09	19209	UTICA MEDICAL CENTER	0	0	0	0	0	192.09
192.10	19210	OGLESBY FAMILY MEDICINE	0	0	0	0	0	192.10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
192.11	19211	FAST CARE	0	0	0	0	0	192.11
192.12	19212	IVCH CARE TODAY	0	0	0	0	0	192.12
192.13	19213	PPCC	0	0	0	0	0	192.13
192.14	19214	ADULT MEDICINE CLINIC	0	0	0	0	0	192.14
192.15	19215	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.15
192.16	19216	STREATOR MEDICAL CLINIC	0	0	0	0	0	192.16
192.17	19217	STREATOR ORTHO CLINIC	0	0	0	0	0	192.17
194.00	07950	OTHER PHYSICIANS OFFICES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,091,829	518,170	1,440,231	1,336,552	349,983	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.265429	0.258318	0.574577	0.006093	67.278547	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	42,909	66,880	44,236	53,948	14,419	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.128332	0.033341	0.017648	0.000246	2.771819	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Worksheet C
Part I
Date/Time Prepared:
1/28/2022 2:57 pm

				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	8,190,930		8,190,930	0	8,190,930	30.00	
31.00	03100	INTENSIVE CARE UNIT	1,889,565		1,889,565	0	1,889,565	31.00	
43.00	04300	NURSERY	734,110		734,110	0	734,110	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	5,141,682		5,141,682	0	5,141,682	50.00	
50.01	05001	SAME DAY SURGERY	1,152,868		1,152,868	0	1,152,868	50.01	
50.02	05002	LITHOTRIPSY	0		0	0	0	50.02	
50.03	05003	ENDOSCOPY	698,253		698,253	0	698,253	50.03	
51.00	05100	RECOVERY ROOM	437,657		437,657	0	437,657	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	716,314		716,314	0	716,314	52.00	
53.00	05300	ANESTHESIOLOGY	793,494		793,494	0	793,494	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,389,066		5,389,066	0	5,389,066	54.00	
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00	
60.00	06000	LABORATORY	4,801,122		4,801,122	0	4,801,122	60.00	
64.00	06400	INTRAVENOUS THERAPY	485,764		485,764	0	485,764	64.00	
65.00	06500	RESPIRATORY THERAPY	787,917	0	787,917	0	787,917	65.00	
66.00	06600	PHYSICAL THERAPY	2,354,418	0	2,354,418	0	2,354,418	66.00	
67.00	06700	OCCUPATIONAL THERAPY	220,747	0	220,747	0	220,747	67.00	
68.00	06800	SPEECH PATHOLOGY	108,176	0	108,176	0	108,176	68.00	
69.00	06900	ELECTROCARDIOLOGY	368,790		368,790	0	368,790	69.00	
69.02	06902	CARDIAC REHAB	352,879		352,879	0	352,879	69.02	
69.03	06903	WOUND CARE	1,348,665		1,348,665	0	1,348,665	69.03	
70.00	07000	ELECTROENCEPHALOGRAPHY	154,301		154,301	0	154,301	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	472,301		472,301	0	472,301	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,535,368		2,535,368	0	2,535,368	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,575,116		4,575,116	0	4,575,116	73.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	4,120,884		4,120,884	0	4,120,884	88.00	
88.01	08801	RURAL HEALTH CLINIC II	1,114,345		1,114,345	0	1,114,345	88.01	
88.02	08802	RURAL HEALTH CLINIC III	1,872,084		1,872,084	0	1,872,084	88.02	
88.03	08803	RURAL HEALTH CLINIC IV	2,634,567		2,634,567	0	2,634,567	88.03	
88.04	08804	RURAL HEALTH CLINIC V	1,628,896		1,628,896	0	1,628,896	88.04	
90.00	09000	CLINIC	4,043,971		4,043,971	0	4,043,971	90.00	
91.00	09100	EMERGENCY	2,905,633		2,905,633	0	2,905,633	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,622,718		2,622,718	0	2,622,718	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	146,374		146,374	0	146,374	95.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
114.00	11400	UTILIZATION REVIEW-SNF						114.00	
116.00	11600	HOSPICE	598,547		598,547		598,547	116.00	
200.00		Subtotal (see instructions)	65,397,522	0	65,397,522	0	65,397,522	200.00	
201.00		Less Observation Beds	2,622,718		2,622,718		2,622,718	201.00	
202.00		Total (see instructions)	62,774,804	0	62,774,804	0	62,774,804	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
1/28/2022 2:57 pm

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,359,796		6,359,796		30.00
31.00	03100	INTENSIVE CARE UNIT	3,576,487		3,576,487		31.00
43.00	04300	NURSERY	987,780		987,780		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,504,863	23,894,820	28,399,683	0.181047	50.00
50.01	05001	SAME DAY SURGERY	0	2,036,945	2,036,945	0.565979	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0.000000	50.02
50.03	05003	ENDOSCOPY	293,001	3,900,247	4,193,248	0.166518	50.03
51.00	05100	RECOVERY ROOM	629,458	2,560,878	3,190,336	0.137182	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	722,411	290,326	1,012,737	0.707305	52.00
53.00	05300	ANESTHESIOLOGY	651,173	4,958,779	5,609,952	0.141444	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,436,158	45,438,765	49,874,923	0.108052	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	5,059,866	32,268,182	37,328,048	0.128620	60.00
64.00	06400	INTRAVENOUS THERAPY	11,990	808,749	820,739	0.591862	64.00
65.00	06500	RESPIRATORY THERAPY	821,736	681,447	1,503,183	0.524166	65.00
66.00	06600	PHYSICAL THERAPY	678,486	4,529,972	5,208,458	0.452037	66.00
67.00	06700	OCCUPATIONAL THERAPY	124,852	474,102	598,954	0.368554	67.00
68.00	06800	SPEECH PATHOLOGY	32,311	426,998	459,309	0.235519	68.00
69.00	06900	ELECTROCARDIOLOGY	493,257	3,635,837	4,129,094	0.089315	69.00
69.02	06902	CARDIAC REHAB	0	460,193	460,193	0.766807	69.02
69.03	06903	WOUND CARE	0	4,251,990	4,251,990	0.317184	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	972	673,188	674,160	0.228879	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,292,553	523,482	1,816,035	0.260073	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,731,477	3,350,412	5,081,889	0.498903	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,213,388	11,977,519	17,190,907	0.266136	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	4,099,107	4,099,107		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	980,582	980,582		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,590,925	1,590,925		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	2,542,109	2,542,109		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,634,076	1,634,076		88.04
90.00	09000	CLINIC	0	6,348,938	6,348,938	0.636952	90.00
91.00	09100	EMERGENCY	2,766,073	10,476,774	13,242,847	0.219412	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	462,360	3,062,180	3,524,540	0.744131	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,333	7,417	10,750	13.616186	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	613,618	613,618		116.00
200.00		Subtotal (see instructions)	40,853,781	178,498,557	219,352,338		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	40,853,781	178,498,557	219,352,338		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.181047			50.00
50.01	05001	SAME DAY SURGERY	0.565979			50.01
50.02	05002	LITHOTRIPSY	0.000000			50.02
50.03	05003	ENDOSCOPY	0.166518			50.03
51.00	05100	RECOVERY ROOM	0.137182			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.707305			52.00
53.00	05300	ANESTHESIOLOGY	0.141444			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.108052			54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.128620			60.00
64.00	06400	INTRAVENOUS THERAPY	0.591862			64.00
65.00	06500	RESPIRATORY THERAPY	0.524166			65.00
66.00	06600	PHYSICAL THERAPY	0.452037			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.368554			67.00
68.00	06800	SPEECH PATHOLOGY	0.235519			68.00
69.00	06900	ELECTROCARDIOLOGY	0.089315			69.00
69.02	06902	CARDIAC REHAB	0.766807			69.02
69.03	06903	WOUND CARE	0.317184			69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.228879			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.260073			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.498903			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.266136			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
88.04	08804	RURAL HEALTH CLINIC V				88.04
90.00	09000	CLINIC	0.636952			90.00
91.00	09100	EMERGENCY	0.219412			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.744131			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	13.616186			95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
116.00	11600	HOSPICE				116.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
1/28/2022 2:57 pm

			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	8,190,930		8,190,930	0	8,190,930
31.00	03100	INTENSIVE CARE UNIT	1,889,565		1,889,565	0	1,889,565
43.00	04300	NURSERY	734,110		734,110	0	734,110
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,141,682		5,141,682	0	5,141,682
50.01	05001	SAME DAY SURGERY	1,152,868		1,152,868	0	1,152,868
50.02	05002	LITHOTRIPSY	0		0	0	0
50.03	05003	ENDOSCOPY	698,253		698,253	0	698,253
51.00	05100	RECOVERY ROOM	437,657		437,657	0	437,657
52.00	05200	DELIVERY ROOM & LABOR ROOM	716,314		716,314	0	716,314
53.00	05300	ANESTHESIOLOGY	793,494		793,494	0	793,494
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,389,066		5,389,066	0	5,389,066
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0
60.00	06000	LABORATORY	4,801,122		4,801,122	0	4,801,122
64.00	06400	INTRAVENOUS THERAPY	485,764		485,764	0	485,764
65.00	06500	RESPIRATORY THERAPY	787,917	0	787,917	0	787,917
66.00	06600	PHYSICAL THERAPY	2,354,418	0	2,354,418	0	2,354,418
67.00	06700	OCCUPATIONAL THERAPY	220,747	0	220,747	0	220,747
68.00	06800	SPEECH PATHOLOGY	108,176	0	108,176	0	108,176
69.00	06900	ELECTROCARDIOLOGY	368,790		368,790	0	368,790
69.02	06902	CARDIAC REHAB	352,879		352,879	0	352,879
69.03	06903	WOUND CARE	1,348,665		1,348,665	0	1,348,665
70.00	07000	ELECTROENCEPHALOGRAPHY	154,301		154,301	0	154,301
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	472,301		472,301	0	472,301
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,535,368		2,535,368	0	2,535,368
73.00	07300	DRUGS CHARGED TO PATIENTS	4,575,116		4,575,116	0	4,575,116
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	4,120,884		4,120,884	0	4,120,884
88.01	08801	RURAL HEALTH CLINIC II	1,114,345		1,114,345	0	1,114,345
88.02	08802	RURAL HEALTH CLINIC III	1,872,084		1,872,084	0	1,872,084
88.03	08803	RURAL HEALTH CLINIC IV	2,634,567		2,634,567	0	2,634,567
88.04	08804	RURAL HEALTH CLINIC V	1,628,896		1,628,896	0	1,628,896
90.00	09000	CLINIC	4,043,971		4,043,971	0	4,043,971
91.00	09100	EMERGENCY	2,905,633		2,905,633	0	2,905,633
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,622,718		2,622,718	0	2,622,718
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	146,374		146,374	0	146,374
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
114.00	11400	UTILIZATION REVIEW-SNF					
116.00	11600	HOSPICE	598,547		598,547		598,547
200.00		Subtotal (see instructions)	65,397,522	0	65,397,522	0	65,397,522
201.00		Less Observation Beds	2,622,718		2,622,718		2,622,718
202.00		Total (see instructions)	62,774,804	0	62,774,804	0	62,774,804

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
1/28/2022 2:57 pm

			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,359,796		6,359,796			30.00
31.00	03100	INTENSIVE CARE UNIT	3,576,487		3,576,487			31.00
43.00	04300	NURSERY	987,780		987,780			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,504,863	23,894,820	28,399,683	0.181047	0.000000	50.00
50.01	05001	SAME DAY SURGERY	0	2,036,945	2,036,945	0.565979	0.000000	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0.000000	0.000000	50.02
50.03	05003	ENDOSCOPY	293,001	3,900,247	4,193,248	0.166518	0.000000	50.03
51.00	05100	RECOVERY ROOM	629,458	2,560,878	3,190,336	0.137182	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	722,411	290,326	1,012,737	0.707305	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	651,173	4,958,779	5,609,952	0.141444	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,436,158	45,438,765	49,874,923	0.108052	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	5,059,866	32,268,182	37,328,048	0.128620	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	11,990	808,749	820,739	0.591862	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	821,736	681,447	1,503,183	0.524166	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	678,486	4,529,972	5,208,458	0.452037	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	124,852	474,102	598,954	0.368554	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	32,311	426,998	459,309	0.235519	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	493,257	3,635,837	4,129,094	0.089315	0.000000	69.00
69.02	06902	CARDIAC REHAB	0	460,193	460,193	0.766807	0.000000	69.02
69.03	06903	WOUND CARE	0	4,251,990	4,251,990	0.317184	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	972	673,188	674,160	0.228879	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,292,553	523,482	1,816,035	0.260073	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,731,477	3,350,412	5,081,889	0.498903	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,213,388	11,977,519	17,190,907	0.266136	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	4,099,107	4,099,107	1.005313	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	980,582	980,582	1.136412	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,590,925	1,590,925	1.176727	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	2,542,109	2,542,109	1.036371	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,634,076	1,634,076	0.996830	0.000000	88.04
90.00	09000	CLINIC	0	6,348,938	6,348,938	0.636952	0.000000	90.00
91.00	09100	EMERGENCY	2,766,073	10,476,774	13,242,847	0.219412	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	462,360	3,062,180	3,524,540	0.744131	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,333	7,417	10,750	13.616186	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	613,618	613,618			116.00
200.00		Subtotal (see instructions)	40,853,781	178,498,557	219,352,338			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	40,853,781	178,498,557	219,352,338			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
50.01	05001	SAME DAY SURGERY	0.000000			50.01
50.02	05002	LITHOTRIPSY	0.000000			50.02
50.03	05003	ENDOSCOPY	0.000000			50.03
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
69.02	06902	CARDIAC REHAB	0.000000			69.02
69.03	06903	WOUND CARE	0.000000			69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000			88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000			88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000			88.04
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
116.00	11600	HOSPICE				116.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 14-0234		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part I Date/Time Prepared: 1/28/2022 2:57 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)			
		1.00	2.00	3.00	4.00	5.00			
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	879,551	1,385	878,166	6,308	139.21	30.00		
31.00	INTENSIVE CARE UNIT	112,406		112,406	864	130.10	31.00		
43.00	NURSERY	12,088		12,088	576	20.99	43.00		
200.00	Total (lines 30 through 199)	1,004,045		1,002,660	7,748		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	2,464	343,013					30.00	
31.00	INTENSIVE CARE UNIT	348	45,275					31.00	
43.00	NURSERY	0	0					43.00	
200.00	Total (lines 30 through 199)	2,812	388,288					200.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
1/28/2022 2:57 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	253,869	28,399,683	0.008939	2,256,180	20,168	50.00
50.01	05001	SAME DAY SURGERY	98,164	2,036,945	0.048192	0	0	50.01
50.02	05002	LITHOTRIPSY	0	0	0.000000	0	0	50.02
50.03	05003	ENDOSCOPY	10,316	4,193,248	0.002460	195,890	482	50.03
51.00	05100	RECOVERY ROOM	25,508	3,190,336	0.007995	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,801	1,012,737	0.011653	0	0	52.00
53.00	05300	ANESTHESIOLOGY	59,273	5,609,952	0.010566	269,792	2,851	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	252,124	49,874,923	0.005055	4,420,294	22,345	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	135,059	37,328,048	0.003618	4,563,642	16,511	60.00
64.00	06400	INTRAVENOUS THERAPY	95,694	820,739	0.116595	11,990	1,398	64.00
65.00	06500	RESPIRATORY THERAPY	45,574	1,503,183	0.030318	589,635	17,877	65.00
66.00	06600	PHYSICAL THERAPY	137,784	5,208,458	0.026454	450,136	11,908	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,687	598,954	0.004486	83,875	376	67.00
68.00	06800	SPEECH PATHOLOGY	1,434	459,309	0.003122	21,850	68	68.00
69.00	06900	ELECTROCARDIOLOGY	18,424	4,129,094	0.004462	490,487	2,189	69.00
69.02	06902	CARDIAC REHAB	81,135	460,193	0.176306	0	0	69.02
69.03	06903	WOUND CARE	14,659	4,251,990	0.003448	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	3,982	674,160	0.005907	972	6	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,292	1,816,035	0.007870	742,142	5,841	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	76,423	5,081,889	0.015038	768,143	11,551	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	75,677	17,190,907	0.004402	3,333,116	14,672	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	210,350	4,099,107	0.051316	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	10,651	980,582	0.010862	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	97,427	1,590,925	0.061239	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	122,104	2,542,109	0.048033	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	15,562	1,634,076	0.009523	0	0	88.04
90.00	09000	CLINIC	253,545	6,348,938	0.039935	0	0	90.00
91.00	09100	EMERGENCY	122,004	13,242,847	0.009213	1,642,783	15,135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	281,630	3,524,540	0.079905	458,358	36,625	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,527,152	207,803,907		20,299,285	180,003	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0234		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 1/28/2022 2:57 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
200.00	Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	6,308	0.00	2,464	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	864	0.00	348	0	31.00	
43.00	04300	NURSERY		0	576	0.00	0	0	43.00	
200.00	Total (lines 30 through 199)			0	7,748		2,812	0	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost						
			9.00	13.00						
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0	0						31.00
43.00	04300	NURSERY	0	0						43.00
200.00	Total (lines 30 through 199)		0	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	0	0	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	0	0	0	0	0	50.03
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.02	06902	CARDIAC REHAB	0	0	0	0	0	69.02
69.03	06903	WOUND CARE	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0234		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 1/28/2022 2:57 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	28,399,683	0.000000	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	2,036,945	0.000000	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	0.000000	50.02
50.03	05003	ENDOSCOPY	0	0	0	4,193,248	0.000000	50.03
51.00	05100	RECOVERY ROOM	0	0	0	3,190,336	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,012,737	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,609,952	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	49,874,923	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	37,328,048	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	820,739	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,503,183	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,208,458	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	598,954	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	459,309	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,129,094	0.000000	69.00
69.02	06902	CARDIAC REHAB	0	0	0	460,193	0.000000	69.02
69.03	06903	WOUND CARE	0	0	0	4,251,990	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	674,160	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,816,035	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,081,889	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	17,190,907	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,099,107	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	980,582	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,590,925	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	2,542,109	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	1,634,076	0.000000	88.04
90.00	09000	CLINIC	0	0	0	6,348,938	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	13,242,847	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,524,540	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	207,803,907		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	2,256,180	0	9,321,523	0	50.00
50.01	05001	SAME DAY SURGERY	0.000000	0	0	864,684	0	50.01
50.02	05002	LITHOTRIPSY	0.000000	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	0.000000	195,890	0	1,306,186	0	50.03
51.00	05100	RECOVERY ROOM	0.000000	0	0	821,346	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	269,792	0	2,016,765	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	4,420,294	0	15,416,389	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	4,563,642	0	4,225,049	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	11,990	0	419,890	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	589,635	0	233,536	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	450,136	0	89,309	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	83,875	0	12,789	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	21,850	0	2,490	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	490,487	0	1,181,426	0	69.00
69.02	06902	CARDIAC REHAB	0.000000	0	0	281,917	0	69.02
69.03	06903	WOUND CARE	0.000000	0	0	2,983,484	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	972	0	271,709	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	742,142	0	149,627	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	768,143	0	1,771,019	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,333,116	0	5,066,649	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
90.00	09000	CLINIC	0.000000	0	0	515,815	0	90.00
91.00	09100	EMERGENCY	0.000000	1,642,783	0	2,728,609	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	458,358	0	1,281,290	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		20,299,285	0	50,961,501	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0234		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 1/28/2022 2:57 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost				
				21.00	24.00				
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
50.01	05001	SAME DAY SURGERY	0	0					50.01
50.02	05002	LITHOTRIPSY	0	0					50.02
50.03	05003	ENDOSCOPY	0	0					50.03
51.00	05100	RECOVERY ROOM	0	0					51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0					59.00
60.00	06000	LABORATORY	0	0					60.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
69.02	06902	CARDIAC REHAB	0	0					69.02
69.03	06903	WOUND CARE	0	0					69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0					88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0					88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0					88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0					88.04
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)	0	0					200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0234		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 1/28/2022 2:57 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
					PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.181047	9,321,523	0	0	1,687,634	50.00
50.01	05001	SAME DAY SURGERY		0.565979	864,684	0	0	489,393	50.01
50.02	05002	LITHOTRIPSY		0.000000	0	0	0	0	50.02
50.03	05003	ENDOSCOPY		0.166518	1,306,186	0	0	217,503	50.03
51.00	05100	RECOVERY ROOM		0.137182	821,346	0	0	112,674	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.707305	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.141444	2,016,765	0	0	285,259	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.108052	15,416,389	0	165	1,665,772	54.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.128620	4,225,049	30,250	0	543,426	60.00
64.00	06400	INTRAVENOUS THERAPY		0.591862	419,890	0	0	248,517	64.00
65.00	06500	RESPIRATORY THERAPY		0.524166	233,536	0	0	122,412	65.00
66.00	06600	PHYSICAL THERAPY		0.452037	89,309	0	0	40,371	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.368554	12,789	0	0	4,713	67.00
68.00	06800	SPEECH PATHOLOGY		0.235519	2,490	0	0	586	68.00
69.00	06900	ELECTROCARDIOLOGY		0.089315	1,181,426	0	0	105,519	69.00
69.02	06902	CARDIAC REHAB		0.766807	281,917	0	0	216,176	69.02
69.03	06903	WOUND CARE		0.317184	2,983,484	0	493	946,313	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY		0.228879	271,709	0	0	62,188	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.260073	149,627	0	0	38,914	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.498903	1,771,019	0	0	883,567	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.266136	5,066,649	0	2,028	1,348,418	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
88.01	08801	RURAL HEALTH CLINIC II							88.01
88.02	08802	RURAL HEALTH CLINIC III							88.02
88.03	08803	RURAL HEALTH CLINIC IV							88.03
88.04	08804	RURAL HEALTH CLINIC V							88.04
90.00	09000	CLINIC		0.636952	515,815	0	137	328,549	90.00
91.00	09100	EMERGENCY		0.219412	2,728,609	0	0	598,690	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.744131	1,281,290	0	0	953,448	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		13.616186		0			95.00
200.00		Subtotal (see instructions)			50,961,501	30,250	2,823	10,900,042	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			50,961,501	30,250	2,823	10,900,042	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0234		Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Prepared: 1/28/2022 2:57 pm
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
50.01	05001	SAME DAY SURGERY	0	0		50.01
50.02	05002	LITHOTRIPSY	0	0		50.02
50.03	05003	ENDOSCOPY	0	0		50.03
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	3,891	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.02	06902	CARDIAC REHAB	0	0		69.02
69.03	06903	WOUND CARE	0	156		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	540		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
88.04	08804	RURAL HEALTH CLINIC V				88.04
90.00	09000	CLINIC	0	87		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	3,891	801		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,891	801		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0234	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 1/28/2022 2:57 pm	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,361	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,308	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)		4,285	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)		53	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)		2,464	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)		22	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)		23	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		237.99	17.00	
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		243.34	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)		8,190,930	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)		12,897	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)		12,897	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		8,178,033	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)		8,178,033	37.00	
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,296.45	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,194,453	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)		3,194,453	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
1/28/2022 2:57 pm

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)	0	0	0.00	0	0
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	1,889,565	864	2,187.00	348	761,076
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
	Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,308,407
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,263,936
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					388,288
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					180,003
52.00	Total Program excludable cost (sum of lines 50 and 51)					568,291
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,695,645
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
	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)					5,236
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					5,597
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					10,833
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
	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)					
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00	Program routine service cost (line 9 x line 71)					
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00	Per diem capital-related costs (line 75 ÷ line 2)					
77.00	Program capital-related costs (line 9 x line 76)					
78.00	Inpatient routine service cost (line 74 minus line 77)					
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00	Inpatient routine service cost per diem limitation					
82.00	Inpatient routine service cost limitation (line 9 x line 81)					
83.00	Reasonable inpatient routine service costs (see instructions)					
84.00	Program inpatient ancillary services (see instructions)					
85.00	Utilization review - physician compensation (see instructions)					
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)					2,023
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,296.45
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,622,718

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description		Title XVIII		Hospital	PPS	
		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	879,551	8,190,930	0.107381	2,622,718	281,630
91.00	Nursing Program cost	0	8,190,930	0.000000	2,622,718	0
92.00	Allied health cost	0	8,190,930	0.000000	2,622,718	0
93.00	All other Medical Education	0	8,190,930	0.000000	2,622,718	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0234	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 1/28/2022 2:57 pm	
			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		2,888,374		30.00
31.00	03100	INTENSIVE CARE UNIT		1,607,407		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.181047	2,256,180	408,475	50.00
50.01	05001	SAME DAY SURGERY	0.565979	0	0	50.01
50.02	05002	LITHOTRIPSY	0.000000	0	0	50.02
50.03	05003	ENDOSCOPY	0.166518	195,890	32,619	50.03
51.00	05100	RECOVERY ROOM	0.137182	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.707305	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.141444	269,792	38,160	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.108052	4,420,294	477,622	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.128620	4,563,642	586,976	60.00
64.00	06400	INTRAVENOUS THERAPY	0.591862	11,990	7,096	64.00
65.00	06500	RESPIRATORY THERAPY	0.524166	589,635	309,067	65.00
66.00	06600	PHYSICAL THERAPY	0.452037	450,136	203,478	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.368554	83,875	30,912	67.00
68.00	06800	SPEECH PATHOLOGY	0.235519	21,850	5,146	68.00
69.00	06900	ELECTROCARDIOLOGY	0.089315	490,487	43,808	69.00
69.02	06902	CARDIAC REHAB	0.766807	0	0	69.02
69.03	06903	WOUND CARE	0.317184	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.228879	972	222	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.260073	742,142	193,011	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.498903	768,143	383,229	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.266136	3,333,116	887,062	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
90.00	09000	CLINIC	0.636952	0	0	90.00
91.00	09100	EMERGENCY	0.219412	1,642,783	360,446	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.744131	458,358	341,078	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		20,299,285	4,308,407	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)		20,299,285		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0234	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3
			Component CCN: 14-U234		Date/Time Prepared: 1/28/2022 2:57 pm
			Title XVIII	Swing Beds - SNF	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			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.181047	0	50.00
50.01	05001	SAME DAY SURGERY	0.565979	0	50.01
50.02	05002	LITHOTRIPSY	0.000000	0	50.02
50.03	05003	ENDOSCOPY	0.166518	0	50.03
51.00	05100	RECOVERY ROOM	0.137182	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.707305	0	52.00
53.00	05300	ANESTHESIOLOGY	0.141444	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.108052	3,274	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.128620	10,758	60.00
64.00	06400	INTRAVENOUS THERAPY	0.591862	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.524166	3,203	65.00
66.00	06600	PHYSICAL THERAPY	0.452037	15,952	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.368554	2,821	67.00
68.00	06800	SPEECH PATHOLOGY	0.235519	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.089315	0	69.00
69.02	06902	CARDIAC REHAB	0.766807	0	69.02
69.03	06903	WOUND CARE	0.317184	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.228879	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.260073	17,986	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.498903	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.266136	36,326	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		88.04
90.00	09000	CLINIC	0.636952	0	90.00
91.00	09100	EMERGENCY	0.219412	1,141	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.744131	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		91,461	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)		91,461	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0234	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 1/28/2022 2:57 pm
		Title XVIII	Hospital	PPS
			1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		1,265,569	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		4,773,976	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2.04
3.00	Managed Care Simulated Payments		1,052,481	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		43.31	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.93	30.00
31.00	Percentage of Medicaid patient days (see instructions)		18.50	31.00
32.00	Sum of lines 30 and 31		20.43	32.00
33.00	Allowable disproportionate share percentage (see instructions)		6.07	33.00
34.00	Disproportionate share adjustment (see instructions)		91,650	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0234	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 1/28/2022 2:57 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	385,745	356,097		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	96,963	266,341		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	363,304			36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0			46.00
47.00	Subtotal (see instructions)	6,494,499			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	8,792,885			48.00
			Amount		
			1.00		
49.00	Total payment for inpatient operating costs (see instructions)		8,218,289		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		455,067		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		34,300		54.00
54.01	Islet isolation add-on payment		0		54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		8,707,656		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		8,707,656		61.00
62.00	Deductibles billed to program beneficiaries		897,776		62.00
63.00	Coinsurance billed to program beneficiaries		14,679		63.00
64.00	Allowable bad debts (see instructions)		179,116		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		116,425		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		129,484		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		7,911,626		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		11,141		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-2,297		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		36,945		70.93
70.94	HRR adjustment amount (see instructions)		-7,060		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0234	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 1/28/2022 2:57 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		87,464	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		7,862,891	71.00
71.01	Sequestration adjustment (see instructions)		0	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		7,796,176	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		66,715	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		434,490	1,289,300
HVPB Adjustment for HSP Bonus Payment				
101.00	HVPB adjustment factor (see instructions)		1.0126492790	1.0043784592
102.00	HVPB adjustment amount for HSP bonus payment (see instructions)		5,496	5,645
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.9959	0.9996
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-1,781	-516
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF DSH PAYMENT PERCENTAGE				Provider CCN: 14-0234	Period: From 07/01/2020 To 06/30/2021	Worksheet DSH Date/Time Prepared: 1/28/2022 2:57 pm	
				Title XVIII	Hospital	PPS	
				Original .mcx Values	Adjusted .mcx Values	HFS Look Up	Override Value
				1.00	2.00	3.00	4.00
							Revised Value
							5.00
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	1.93	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	18.50	0.00				2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	20.43	0.00				3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	MDH				MDH	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	43.31	0.00				5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	6.07	0.00				6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	870	0			870	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	0	0			0	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	215	0			215	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	1,085	0			1,085	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	5,778	0			5,778	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	141	0			141	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	53	0			53	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	5,866	0			5,866	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	18.50	0.00			18.50	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE			Provider CCN: 14-0234		Period: From 07/01/2020 To 06/30/2021		Worksheet DSH Date/Time Prepared: 1/28/2022 2:57 pm	
			Title XVIII		Hospital		PPS	
			Original .mcrx Values		Adjusted .mcax Values		Revised	
			Condition	Percentage	Condition	Percentage	Condition	
			1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE								
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	6.07		0.00	False	28.00	
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	True	29.00	
30.00	Line 28 or 29 as applicable		6.07		0.00		30.00	
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		6.07		0.00		31.00	
			Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
			1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE								
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00	
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00	
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	True				True	34.00	
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00	
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00	

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0234	Period: From 07/01/2020 To 06/30/2021	Worksheet DSH Date/Time Prepared: 1/28/2022 2:57 pm
		Title XVIII	Hospital	PPS
		Revised Percentage 6.00		
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE				
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00	28.00	
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	4.77	29.00	
30.00	Line 28 or 29 as applicable	4.77	30.00	
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00	31.00	

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
1/28/2022 2:57 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,265,569	0	1,265,569		1,265,569
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,773,976	0		4,773,976	4,773,976
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	1,052,481	0	0	1,052,481	1,052,481
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0607	0.0607	0.0607	0.0607	
11.00	Disproportionate share adjustment (see instructions)	34.00	91,650	0	19,205	72,445	91,650
11.01	Uncompensated care payments	36.00	363,304	0	96,963	266,341	363,304
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	6,494,499	0	1,381,737	5,112,762	6,494,499
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	8,792,885	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	8,218,289	0	1,381,737	6,836,552	8,218,289
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	455,067	0	0	455,067	455,067
17.00	Special add-on payments for new technologies	54.00	34,300	0	0	34,300	34,300
17.01	Net organ acquisition cost						

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
1/28/2022 2:57 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	1,381,737	7,325,919	8,707,656
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	454,460	0	0	454,460	454,460
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	607	0	0	607	607
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	455,067	0	0	455,067	455,067
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
1/28/2022 2:57 pm

		Title XVIII		Hospital		PPS
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)
		0	1.00	2.00	3.00	4.00
1.00	DRG amounts other than outlier payments	1.00				1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,265,569	1,265,569		1,265,569
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,773,976		4,773,976	4,773,976
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00				
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0
4.00	Managed care simulated payments	3.00	1,052,481	218,363	834,118	1,052,481
Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0
Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0607	0.0607	0.0607	
11.00	Disproportionate share adjustment (see instructions)	34.00	91,650	19,205	72,445	91,650
11.01	Uncompensated care payments	36.00	363,304	96,963	266,341	363,304
Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0
13.00	Subtotal (see instructions)	47.00	6,494,499	1,381,737	5,112,762	6,494,499
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	8,792,885	1,863,553	6,929,332	8,792,885
15.00	Total payment for inpatient operating costs (see instructions)	49.00	8,218,289	1,743,099	6,475,190	8,218,289
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	455,067	0	455,067	455,067
17.00	Special add-on payments for new technologies	54.00	34,300	0	34,300	34,300
17.01	Net organ acquisition cost					
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0
19.00	SUBTOTAL			1,743,099	6,964,557	8,707,656

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
1/28/2022 2:57 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	454,460	0	454,460	454,460	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	607	0	607	607	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	455,067	0	455,067	455,067	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	36,945	0	36,945	36,945	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	11,141	5,496	5,645	11,141	30.01
31.00	HRR adjustment (see instructions)	70.94	-7,060	0	-7,060	-7,060	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-2,297	-1,781	-516	-2,297	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		17,468	69,996	87,464	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0234	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 1/28/2022 2:57 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,692	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		10,900,042	2.00
3.00	OPPS payments		8,800,732	3.00
4.00	Outlier payment (see instructions)		65,087	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)		4,692	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		33,073	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)		33,073	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		33,073	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		28,381	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)		4,692	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)		8,865,819	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)		1,783,094	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)		7,087,417	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)		7,087,417	30.00
31.00	Primary payer payments		315	31.00
32.00	Subtotal (line 30 minus line 31)		7,087,102	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)		84,306	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		54,799	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		19,956	36.00
37.00	Subtotal (see instructions)		7,141,901	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)		7,141,901	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		7,261,246	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)		-119,345	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

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part B
Date/Time Prepared:
1/28/2022 2:57 pm

Title XVIII

Hospital

PPS

Overrides

1.00

WORKSHEET OVERRIDE VALUES

112.00 Override of Ancillary service charges (line 12)

0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
1/28/2022 2:57 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		7,868,176		7,274,338	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	05/26/2021	72,000	05/26/2021	13,092	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)		-72,000		-13,092	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)		7,796,176		7,261,246	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		66,715		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		119,345	6.02	
7.00	Total Medicare program liability (see instructions)		7,862,891		7,141,901	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0234

Period:

Worksheet E-1

Component CCN: 14-U234

From 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
1/28/2022 2:57 pm

		Title XVIII		Swing Beds - SNF		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		26,374		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		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)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		26,374		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		26,374		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-0234	Period: From 07/01/2020 To 06/30/2021	Worksheet E-2	
		Component CCN: 14-U234		Date/Time Prepared: 1/28/2022 2:57 pm	
		Title XVIII	Swing Beds - SNF	PPS	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		26,374	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		0	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		45	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		26,374	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		26,374	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		26,374	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		26,374	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		26,374	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		26,374	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)		0	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

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

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet G

Date/Time Prepared:
1/28/2022 2:57 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	11,485,885	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	41,580,867	0	0	0	4.00
5.00	Other receivable	3,629,769	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-29,830,208	0	0	0	6.00
7.00	Inventory	2,085,367	0	0	0	7.00
8.00	Prepaid expenses	0	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)	28,951,680	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,476,235	0	0	0	12.00
13.00	Land improvements	1,356,820	0	0	0	13.00
14.00	Accumulated depreciation	-1,222,403	0	0	0	14.00
15.00	Buildings	53,844,784	0	0	0	15.00
16.00	Accumulated depreciation	-38,275,832	0	0	0	16.00
17.00	Leasehold improvements	325,067	0	0	0	17.00
18.00	Accumulated depreciation	-280,796	0	0	0	18.00
19.00	Fixed equipment	14,533,683	0	0	0	19.00
20.00	Accumulated depreciation	-11,573,076	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	46,233,273	0	0	0	23.00
24.00	Accumulated depreciation	-43,588,445	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)	22,829,310	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	8,878,177	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,432,371	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	11,310,548	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	63,091,538	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	6,949,310	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,820,563	0	0	0	38.00
39.00	Payroll taxes payable	67,324	0	0	0	39.00
40.00	Notes and loans payable (short term)	16,393,018	0	0	0	40.00
41.00	Deferred income	95,353	0	0	0	41.00
42.00	Accelerated payments	7,704,252	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	14,375,190	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	48,405,010	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	4,242,370	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,242,370	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	52,647,380	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	10,444,158				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	10,444,158	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	63,091,538	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-1

Date/Time Prepared:
1/28/2022 2:57 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		17,134,892		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-6,690,734				2.00
3.00	Total (sum of line 1 and line 2)		10,444,158		0		3.00
4.00	Additions (credit adjustments) (specify)	0		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)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		10,444,158		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)		10,444,158		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	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	14,179,403		14,179,403	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)	14,179,403		14,179,403	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	4,049,258		4,049,258	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	4,049,258		4,049,258	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	18,228,661		18,228,661	17.00
18.00	Ancillary services	30,443,352	177,628,789	208,072,141	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	4,099,107	4,099,107	20.00
20.01	RURAL HEALTH CLINIC II	0	980,582	980,582	20.01
20.02	RURAL HEALTH CLINIC III	0	1,590,925	1,590,925	20.02
20.03	RURAL HEALTH CLINIC IV	0	2,542,109	2,542,109	20.03
20.04	RURAL HEALTH CLINIC V	0	1,634,076	1,634,076	20.04
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	3,333	7,417	10,750	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	613,618	613,618	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	48,675,346	189,096,623	237,771,969	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		82,088,677		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)		82,088,677		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0234

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-3

Date/Time Prepared:
1/28/2022 2:57 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	237,771,969	1.00
2.00	Less contractual allowances and discounts on patients' accounts	168,029,494	2.00
3.00	Net patient revenues (line 1 minus line 2)	69,742,475	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	82,088,677	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-12,346,202	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	64,691	6.00
7.00	Income from investments	579,069	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	91,994	10.00
11.00	Rebates and refunds of expenses	2,566	11.00
12.00	Parking lot receipts	5,307	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	66,529	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	1,830	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	60	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	441,174	22.00
23.00	Governmental appropriations	0	23.00
24.00	NUTRITION CONSULTATION REVENUE	30,058	24.00
24.01	CBO REVENUE	271,671	24.01
24.02	TRANSPORT VEHICLE REVENUE	221,336	24.02
24.03	MANAGEMENT FEES	60,000	24.03
24.04	MISC REVENUE	62,641	24.04
24.05	GAIN ON DEBT	3,155,883	24.05
24.50	COVID-19 PHE Funding	600,659	24.50
25.00	Total other income (sum of lines 6-24)	5,655,468	25.00
26.00	Total (line 5 plus line 25)	-6,690,734	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)	-6,690,734	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0234

Period:

Worksheet 0

Hospice CCN: 14-1533

From 07/01/2020

To 06/30/2021

Date/Time Prepared:
1/28/2022 2:57 pm

				Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	84,196	30,027	114,223	0	114,223	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	777	777	-471	306	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	3,557	3,557	0	3,557	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	11,757	11,757	0	11,757	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	15,703	15,703	0	15,703	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	15,003	15,003	0	15,003	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	86,217	59,383	145,600	0	145,600	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	15,535	0	15,535	0	15,535	33.00
34.00	SPIRITUAL COUNSELING**	21,512	0	21,512	0	21,512	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	5,697	0	5,697	0	5,697	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	213,157	136,207	349,364	-471	348,893	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0234

Period:

Worksheet 0

Hospice CCN: 14-1533

From 07/01/2020
To 06/30/2021Date/Time Prepared:
1/28/2022 2:57 pm

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	114,223	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	306	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	3,557	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	11,757	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	15,703	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	15,003	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	145,600	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	15,535	33.00
34.00	SPIRITUAL COUNSELING**	0	21,512	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	5,697	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	0	348,893	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 14-0234

Period:

Worksheet 0-2

Hospice CCN: 14-1533

From 07/01/2020

To 06/30/2021

Date/Time Prepared:
1/28/2022 2:57 pm

				Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	15,003	15,003	0	15,003	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	86,217	59,383	145,600	0	145,600	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	15,535	0	15,535	0	15,535	33.00
34.00	SPIRITUAL COUNSELING	21,512	0	21,512	0	21,512	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	5,697	0	5,697	0	5,697	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	128,961	74,386	203,347	0	203,347	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	15,003	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	145,600	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	15,535	33.00
34.00	SPIRITUAL COUNSELING	0	21,512	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	5,697	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	203,347	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET
EXPENSES FOR ALLOCATION

Provider CCN: 14-0234

Period:

Worksheet 0-5

Hospice CCN: 14-1533

From 07/01/2020
To 06/30/2021Date/Time Prepared:
1/28/2022 2:57 pm

Descriptions		Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	10,671	10,671	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	23,990	23,990	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	49,312	49,312	3.00
4.00	ADMINISTRATIVE & GENERAL	114,223	152,919	267,142	4.00
5.00	PLANT OPERATION & MAINTENANCE	306	0	306	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	3,557	0	3,557	10.00
11.00	MEDICAL RECORDS	0	3,739	3,739	11.00
12.00	STAFF TRANSPORTATION	11,757	0	11,757	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	13.00
14.00	PHARMACY	15,703	9,023	24,726	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	203,347	0	203,347	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	348,893	249,654	598,547	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0234

Period:

Worksheet 0-6

Hospice CCN: 14-1533

From 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
1/28/2022 2:57 pm

Descriptions		TOTAL EXPENSES		CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	Hospice I EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	10,671	10,671					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	23,990		23,990				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	49,312	0	0	49,312			3.00
4.00	ADMINISTRATIVE & GENERAL	267,142	10,671	23,990	0	301,803		4.00
5.00	PLANT OPERATION & MAINTENANCE	306	0	0	0	306		5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0		6.00
7.00	HOUSEKEEPING	0	0	0	0	0		7.00
8.00	DIETARY	0	0	0	0	0		8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	3,557	0	0	0	3,557		10.00
11.00	MEDICAL RECORDS	3,739	0	0	0	3,739		11.00
12.00	STAFF TRANSPORTATION	11,757	0	0	0	11,757		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0		13.00
14.00	PHARMACY	24,726	0	0	0	24,726		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0		15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0		17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0		50.00
51.00	HOSPICE ROUTINE HOME CARE	203,347			49,312	252,659		51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0		53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0		60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0		61.00
62.00	FUNDRAISING	0	0	0	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0		66.00
67.00	ADVERTISING	0	0	0	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0		68.00
69.00	THRIFT STORE	0	0	0	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0		71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0		99.00
100.00	TOTAL	598,547	10,671	23,990	49,312	598,547		100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0234

Period:

Worksheet 0-6

Hospice CCN: 14-1533

From 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
1/28/2022 2:57 pm

Descriptions		ADMINISTRATIVE & GENERAL		PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	Hospice I HOUSEKEEPING	DIETARY	
		4.00		5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMINISTRATIVE & GENERAL	301,803						4.00
5.00	PLANT OPERATION & MAINTENANCE	311	617					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0			6.00
7.00	HOUSEKEEPING	0	0			0		7.00
8.00	DIETARY	0	0			0	0	8.00
9.00	NURSING ADMINISTRATION	0	0			0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	3,618	0			0		10.00
11.00	MEDICAL RECORDS	3,803	0			0		11.00
12.00	STAFF TRANSPORTATION	11,957	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0			0		13.00
14.00	PHARMACY	25,148	0			0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0			0		15.00
16.00	OTHER GENERAL SERVICE	0	0			0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0			0		17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0						50.00
51.00	HOSPICE ROUTINE HOME CARE	256,966						51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	617		0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0	0	0	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	0			0		60.00
61.00	VOLUNTEER PROGRAM	0	0			0		61.00
62.00	FUNDRAISING	0	0			0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0			0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0			0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0			0		65.00
66.00	RESIDENTIAL CARE	0	0		0	0	0	66.00
67.00	ADVERTISING	0	0			0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0			0		68.00
69.00	THRIFT STORE	0	0			0		69.00
70.00	NURSING FACILITY ROOM & BOARD							70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0		0	0	0	99.00
100.00	TOTAL	301,803	617		0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0234

Period:

Worksheet 0-6

Hospice CCN: 14-1533

From 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
1/28/2022 2:57 pm

Descriptions		Hospice I					
		NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	7,175				10.00
11.00	MEDICAL RECORDS	0		7,542			11.00
12.00	STAFF TRANSPORTATION	0			23,714		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	7,175	7,542	23,714	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	7,175	7,542	23,714	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0234

Period:

Worksheet 0-6

Hospice CCN: 14-1533

From 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
1/28/2022 2:57 pm

Descriptions		Hospice I				TOTAL	
		PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
		14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	49,874					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	24,937	0	0		572,993	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	24,937	0	0	0	25,554	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	49,874	0	0	0	598,547	100.00

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

Provider CCN: 14-0234

Period:

Worksheet 0-6

Hospice CCN: 14-1533

From 07/01/2020
To 06/30/2021Part II
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Hospice I RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,915					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		1,915				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	213,157			3.00
4.00	ADMINISTRATIVE & GENERAL	1,915	1,915	0	-301,803	296,744	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	306	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	3,557	10.00
11.00	MEDICAL RECORDS	0	0	0	0	3,739	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	11,757	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	24,726	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			213,157		252,659	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	10,671	23,990	49,312		301,803	100.00
101.00	UNIT COST MULTIPLIER	5.572324	12.527415	0.231341		1.017048	101.00

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

Provider CCN: 14-0234

Period:

Worksheet 0-6

Hospice CCN: 14-1533

From 07/01/2020
To 06/30/2021Part II
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	1,915					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,915	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	617	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.322193	0.000000	0.000000	0.000000	0.000000	101.00

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

Provider CCN: 14-0234

Period:

Worksheet 0-6

Hospice CCN: 14-1533

From 07/01/2020
To 06/30/2021Part II
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Descriptions		Hospice I				
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)
		10.00	11.00	12.00	13.00	14.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES	2,447				10.00
11.00	MEDICAL RECORDS		2,447			11.00
12.00	STAFF TRANSPORTATION			100		12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0	13.00
14.00	PHARMACY			0	0	100 14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0 15.00
16.00	OTHER GENERAL SERVICE			0	0	0 16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					0 17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0 50.00
51.00	HOSPICE ROUTINE HOME CARE	2,447	2,447	100	0	50 51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	50 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0 53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0 60.00
61.00	VOLUNTEER PROGRAM			0	0	0 61.00
62.00	FUNDRAISING			0	0	0 62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0 63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0 64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0 65.00
66.00	RESIDENTIAL CARE			0	0	0 66.00
67.00	ADVERTISING			0	0	0 67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0 68.00
69.00	THRIFT STORE			0	0	0 69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0 71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	7,175	7,542	23,714	0	49,874 100.00
101.00	UNIT COST MULTIPLIER	2.932162	3.082141	237.140000	0.000000	498.740000 101.00

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

Provider CCN: 14-0234

Period:

Worksheet 0-6

Hospice CCN: 14-1533

From 07/01/2020
To 06/30/2021Part II
Date/Time Prepared:
1/28/2022 2:57 pm

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE		Provider CCN: 14-0234	Period: From 07/01/2020 To 06/30/2021	Worksheet 0-7
		Hospice CCN: 14-1533		Date/Time Prepared: 1/28/2022 2:57 pm

				Hospice I			
Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				2.00	3.00	4.00	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.452037	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.368554	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.235519	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.266136	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.128620	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.260073	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)	Shared Service Costs by LOC				
		HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0234

Period:

Worksheet 0-8

Hospice CCN: 14-1533

From 07/01/2020
To 06/30/2021Date/Time Prepared:
1/28/2022 2:57 pm

		Hospice I			
		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			572,993	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			2,447	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			234.16	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	2,447	0		9.00
10.00	Program cost (line 8 times line 9)	572,990	0		10.00
HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			25,554	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			0	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			0.00	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	0	0		14.00
15.00	Program cost (line 13 times line 14)	0	0		15.00
HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			0	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			0	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			0.00	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	0	0		19.00
20.00	Program cost (line 18 times line 19)	0	0		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			598,547	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			2,447	22.00
23.00	Average cost per diem (line 21 divided by line 22)			244.60	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0234	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Prepared: 1/28/2022 2:57 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		454,460	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		607	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		14.49	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30)(see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		455,067	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0234

Period:

Worksheet M-1

Component CCN: 14-8564

From 07/01/2020
To 06/30/2021Date/Time Prepared:
1/28/2022 2:57 pm

				RHC I			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	768,480	0	768,480	0	768,480	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	468,689	0	468,689	0	468,689	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	560,892	0	560,892	0	560,892	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,798,061	0	1,798,061	0	1,798,061	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	127,365	127,365	0	127,365	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	234,176	234,176	0	234,176	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	361,541	361,541	0	361,541	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,798,061	361,541	2,159,602	0	2,159,602	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	24,457	0	24,457	0	24,457	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	24,457	0	24,457	0	24,457	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	66,908	66,908	0	66,908	29.00
30.00	Administrative Costs	0	287,511	287,511	0	287,511	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	354,419	354,419	0	354,419	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,822,518	715,960	2,538,478	0	2,538,478	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0234

Period:

Worksheet M-1

Component CCN: 14-8564

From 07/01/2020
To 06/30/2021Date/Time Prepared:
1/28/2022 2:57 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	768,480	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	468,689	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	560,892	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,798,061	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	127,365	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	234,176	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	361,541	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,159,602	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	24,457	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	24,457	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	-60,000	6,908	29.00
30.00	Administrative Costs	0	287,511	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-60,000	294,419	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-60,000	2,478,478	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0234

Period:

Worksheet M-1

Component CCN: 14-8565

From 07/01/2020
To 06/30/2021Date/Time Prepared:
1/28/2022 2:57 pm

				RHC II			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	212,329	0	212,329	0	212,329	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	90,055	0	90,055	0	90,055	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	297,397	0	297,397	0	297,397	9.00
10.00	Subtotal (sum of lines 1 through 9)	599,781	0	599,781	0	599,781	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	7,606	7,606	0	7,606	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	5,344	5,344	0	5,344	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	12,950	12,950	0	12,950	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	599,781	12,950	612,731	0	612,731	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	23,500	0	23,500	0	23,500	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	23,500	0	23,500	0	23,500	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	66,092	66,092	0	66,092	29.00
30.00	Administrative Costs	0	92,709	92,709	0	92,709	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	158,801	158,801	0	158,801	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	623,281	171,751	795,032	0	795,032	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0234

Period:

Worksheet M-1

Component CCN: 14-8565

From 07/01/2020
To 06/30/2021Date/Time Prepared:
1/28/2022 2:57 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	212,329	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	90,055	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	297,397	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	599,781	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	7,606	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	5,344	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	12,950	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	612,731	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	23,500	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	23,500	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	-30,804	35,288	29.00
30.00	Administrative Costs	0	92,709	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-30,804	127,997	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-30,804	764,228	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0234

Period:

Worksheet M-1

Component CCN: 14-8562

From 07/01/2020
To 06/30/2021Date/Time Prepared:
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		RHC III					
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	496,986	0	496,986	0	496,986	1.00
2.00	Physician Assistant	71,736	0	71,736	-46,038	25,698	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	340,237	0	340,237	0	340,237	9.00
10.00	Subtotal (sum of lines 1 through 9)	908,959	0	908,959	-46,038	862,921	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	36,670	36,670	0	36,670	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	5,377	5,377	0	5,377	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	42,047	42,047	0	42,047	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	908,959	42,047	951,006	-46,038	904,968	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	48,748	0	48,748	0	48,748	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	48,748	0	48,748	0	48,748	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	44,084	44,084	0	44,084	29.00
30.00	Administrative Costs	0	170,247	170,247	0	170,247	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	214,331	214,331	0	214,331	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	957,707	256,378	1,214,085	-46,038	1,168,047	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0234

Period:

Worksheet M-1

Component CCN: 14-8562

From 07/01/2020
To 06/30/2021Date/Time Prepared:
1/28/2022 2:57 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	496,986	1.00
2.00	Physician Assistant	0	25,698	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	340,237	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	862,921	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	36,670	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	5,377	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	42,047	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	904,968	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	48,748	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	48,748	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	44,084	29.00
30.00	Administrative Costs	-17,160	153,087	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-17,160	197,171	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-17,160	1,150,887	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0234

Period:

Worksheet M-1

Component CCN: 14-8563

From 07/01/2020
To 06/30/2021Date/Time Prepared:
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				RHC IV			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	706,151	0	706,151	0	706,151	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	69,990	0	69,990	0	69,990	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	299,760	0	299,760	0	299,760	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,075,901	0	1,075,901	0	1,075,901	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	273,700	273,700	0	273,700	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	7,961	7,961	0	7,961	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	281,661	281,661	0	281,661	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,075,901	281,661	1,357,562	0	1,357,562	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	9,716	0	9,716	0	9,716	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	9,716	0	9,716	0	9,716	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	42,990	42,990	0	42,990	29.00
30.00	Administrative Costs	0	257,424	257,424	0	257,424	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	300,414	300,414	0	300,414	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,085,617	582,075	1,667,692	0	1,667,692	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0234

Period:

Worksheet M-1

Component CCN: 14-8563

From 07/01/2020
To 06/30/2021Date/Time Prepared:
1/28/2022 2:57 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC IV	
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	706,151		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	69,990		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	299,760		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,075,901		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	273,700		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	7,961		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	281,661		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,357,562		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	9,716		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	9,716		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	-36,000	6,990		29.00
30.00	Administrative Costs	0	257,424		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-36,000	264,414		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-36,000	1,631,692		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0234

Period:

Worksheet M-1

Component CCN: 14-8561

From 07/01/2020
To 06/30/2021Date/Time Prepared:
1/28/2022 2:57 pm

				RHC V			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	292,284	0	292,284	0	292,284	1.00
2.00	Physician Assistant	193,287	0	193,287	0	193,287	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	296,214	0	296,214	0	296,214	9.00
10.00	Subtotal (sum of lines 1 through 9)	781,785	0	781,785	0	781,785	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	110,653	110,653	0	110,653	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	10,024	10,024	0	10,024	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	120,677	120,677	0	120,677	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	781,785	120,677	902,462	0	902,462	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	55,215	0	55,215	0	55,215	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	55,215	0	55,215	0	55,215	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	98,457	98,457	0	98,457	29.00
30.00	Administrative Costs	0	127,114	127,114	0	127,114	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	225,571	225,571	0	225,571	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	837,000	346,248	1,183,248	0	1,183,248	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0234

Period:

Worksheet M-1

Component CCN: 14-8561

From 07/01/2020
To 06/30/2021Date/Time Prepared:
1/28/2022 2:57 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	292,284	1.00
2.00	Physician Assistant	0	193,287	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	296,214	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	781,785	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	110,653	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	10,024	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	120,677	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	902,462	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	55,215	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	55,215	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	-50,000	48,457	29.00
30.00	Administrative Costs	0	127,114	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-50,000	175,571	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-50,000	1,133,248	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0234

Period:

Worksheet M-2

Component CCN: 14-8564

From 07/01/2020
To 06/30/2021Date/Time Prepared:
1/28/2022 2:57 pm

		RHC I				
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.05	3,789	1	1	1.00
2.00	Physician Assistant	0.00	0	1	0	2.00
3.00	Nurse Practitioner	1.69	5,399	1	2	3.00
4.00	Subtotal (sum of lines 1 through 3)	2.74	9,188		3	4.00
5.00	Visiting Nurse	0.00	0			5.00
6.00	Clinical Psychologist	0.00	0			6.00
7.00	Clinical Social Worker	0.00	0			7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.74	9,188			8.00
9.00	Physician Services Under Agreements		0			9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				2,159,602	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				24,457	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				2,184,059	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.988802	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				294,419	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,642,406	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,936,825	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,936,825	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,915,136	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				4,074,738	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0234

Period:

Worksheet M-2

Component CCN: 14-8565

From 07/01/2020
To 06/30/2021Date/Time Prepared:
1/28/2022 2:57 pm

		RHC II				
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.86	2,748	1	1	1.00
2.00	Physician Assistant	0.00	0	1	0	2.00
3.00	Nurse Practitioner	0.61	1,336	1	1	3.00
4.00	Subtotal (sum of lines 1 through 3)	1.47	4,084	2	4,084	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.47	4,084		4,084	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				612,731	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				23,500	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				636,231	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.963064	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				127,997	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				350,117	15.00
16.00	Total overhead (sum of lines 14 and 15)				478,114	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				478,114	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				460,454	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				1,073,185	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0234

Period:

Worksheet M-2

Component CCN: 14-8562

From 07/01/2020
To 06/30/2021Date/Time Prepared:
1/28/2022 2:57 pm

		RHC III					
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.92	4,510	1	1		1.00
2.00	Physician Assistant	0.32	811	1	0		2.00
3.00	Nurse Practitioner	0.00	0	1	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.24	5,321		1	5,321	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.24	5,321			5,321	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					904,968	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					48,748	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					953,716	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.948886	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					197,171	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					721,197	15.00
16.00	Total overhead (sum of lines 14 and 15)					918,368	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					918,368	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					871,427	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,776,395	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0234

Period:

Worksheet M-2

Component CCN: 14-8563

From 07/01/2020
To 06/30/2021Date/Time Prepared:
1/28/2022 2:57 pm

		RHC IV				
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	2.67	7,364	1	3	1.00
2.00	Physician Assistant	0.00	0	1	0	2.00
3.00	Nurse Practitioner	0.54	679	1	1	3.00
4.00	Subtotal (sum of lines 1 through 3)	3.21	8,043		4	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.21	8,043		8,043	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				1,357,562	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				9,716	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,367,278	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.992894	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				264,414	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,002,875	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,267,289	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,267,289	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,258,284	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				2,615,846	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0234

Period:

Worksheet M-2

Component CCN: 14-8561

From 07/01/2020
To 06/30/2021Date/Time Prepared:
1/28/2022 2:57 pm

		RHC V				
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.11	1,976	1	1	1.00
2.00	Physician Assistant	1.55	3,455	1	2	2.00
3.00	Nurse Practitioner	0.00	0	1	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2.66	5,431		3	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.66	5,431		5,431	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				902,462	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				55,215	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				957,677	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.942345	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				175,571	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				495,648	15.00
16.00	Total overhead (sum of lines 14 and 15)				671,219	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				671,219	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				632,520	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				1,534,982	20.00

Health Financial Systems		ST. MARGARETS HEALTH - PERU		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0234	Period: From 07/01/2020	Worksheet M-3	
		Component CCN: 14-8564	To 06/30/2021	Date/Time Prepared: 1/28/2022 2:57 pm	
		Title XVIII	RHC I		
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			4,074,738	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			4,074,738	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			9,188	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			9,188	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			443.48	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	318.19	8.00
9.00	Rate for Program covered visits (see instructions)	443.48	443.48	318.19	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	232	81	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	102,887	25,773	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	128,660		16.00
16.01	Total program charges (see instructions)(from contractor's records)		60,867		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,318		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		7,014		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		93,824		16.04
16.05	Total program cost (see instructions)	0	100,838		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,366		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		10,637		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		100,838		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		100,838		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		100,838		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		77,701		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		23,137		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0234 Component CCN: 14-8565	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 1/28/2022 2:57 pm	
		Title XVIII	RHC II		
			1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,073,185	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,073,185	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,084	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			4,084	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			262.78	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	238.45	8.00
9.00	Rate for Program covered visits (see instructions)	262.78	262.78	238.45	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	773	238	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	203,129	56,751	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	259,880		16.00
16.01	Total program charges (see instructions)(from contractor's records)		205,263		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		89,829		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		113,731		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		104,482		16.04
16.05	Total program cost (see instructions)	0	218,213		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		15,547		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		19,977		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		218,213		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		218,213		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		218,213		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		195,826		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		22,387		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

Health Financial Systems		ST. MARGARETS HEALTH - PERU		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0234 Component CCN: 14-8562		Period: From 07/01/2020 To 06/30/2021 Worksheet M-3 Date/Time Prepared: 1/28/2022 2:57 pm	
		Title XVIII		RHC III	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,776,395	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			51,169	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,725,226	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,321	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			5,321	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			324.23	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	0.00	376.83 8.00
9.00	Rate for Program covered visits (see instructions)		324.23	324.23	324.23 9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	2,492	771 10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	807,981	249,981 11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	0 12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	0 13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	0 14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	1,057,962	
16.01	Total program charges (see instructions)(from contractor's records)			658,188	
16.02	Total program preventive charges (see instructions)(from provider's records)			43,259	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			69,533	
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			729,851	
16.05	Total program cost (see instructions)		0	799,384	
17.00	Primary payer amounts			0	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			76,115	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			107,763	
20.00	Net Medicare cost excluding vaccines (see instructions)			799,384	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			36,601	
22.00	Total reimbursable Program cost (line 20 plus line 21)			835,985	
23.00	Allowable bad debts (see instructions)			0	
23.01	Adjusted reimbursable bad debts (see instructions)			0	
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	
25.99	Demonstration payment adjustment amount before sequestration			0	
26.00	Net reimbursable amount (see instructions)			835,985	
26.01	Sequestration adjustment (see instructions)			0	
26.02	Demonstration payment adjustment amount after sequestration			0	
27.00	Interim payments			921,983	
28.00	Tentative settlement (for contractor use only)			0	
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			-85,998	
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0234 Component CCN: 14-8563	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 1/28/2022 2:57 pm	
		Title XVIII	RHC IV		
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,615,846	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			135,613	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,480,233	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,043	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			8,043	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			308.37	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	251.05	8.00
9.00	Rate for Program covered visits (see instructions)	308.37	308.37	251.05	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,460	497	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	450,220	124,772	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	574,992		16.00
16.01	Total program charges (see instructions)(from contractor's records)		359,091		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		80,090		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		128,243		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		332,629		16.04
16.05	Total program cost (see instructions)	0	460,872		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		30,963		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		49,608		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		460,872		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		8,587		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		469,459		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		469,459		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		378,976		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		90,483		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0234 Component CCN: 14-8561	Period: From 07/01/2020 To 06/30/2021	Worksheet M-3 Date/Time Prepared: 1/28/2022 2:57 pm	
		Title XVIII	RHC V		
			1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,534,982	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			43,864	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,491,118	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,431	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			5,431	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			274.56	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	188.55	8.00
9.00	Rate for Program covered visits (see instructions)	274.56	274.56	188.55	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	891	329	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	244,633	62,033	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	306,666		16.00
16.01	Total program charges (see instructions)(from contractor's records)		247,393		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		52,805		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		65,457		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		170,016		16.04
16.05	Total program cost (see instructions)	0	235,473		16.05
17.00	Primary payer amounts		75		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		28,689		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		33,180		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		235,398		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		9,540		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		244,938		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		244,938		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		166,725		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		78,213		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0234

Period:

Worksheet M-4

Component CCN: 14-8562

From 07/01/2020
To 06/30/2021Date/Time Prepared:
1/28/2022 2:57 pm

		Title XVIII		RHC III		
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	862,921	862,921	862,921	862,921	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000881	0.004328	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	760	3,735	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	11,455	10,117	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	12,215	13,852	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	904,968	904,968	904,968	904,968	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	871,427	871,427	871,427	871,427	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.013498	0.015307	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	11,763	13,339	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	23,978	27,191	0	0	10.00
11.00	Total number of injections/infusions (from your records)	122	599	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	196.54	45.39	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	89	421	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	17,492	19,109	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		51,169			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		36,601			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0234

Period:

Worksheet M-4

Component CCN: 14-8563

From 07/01/2020
To 06/30/2021Date/Time Prepared:
1/28/2022 2:57 pm

		Title XVIII		RHC IV		
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,075,901	1,075,901	1,075,901	1,075,901	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002228	0.003890	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	2,397	4,185	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	33,237	30,560	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	35,634	34,745	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,357,562	1,357,562	1,357,562	1,357,562	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,258,284	1,258,284	1,258,284	1,258,284	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.026249	0.025594	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	33,029	32,205	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	68,663	66,950	0	0	10.00
11.00	Total number of injections/infusions (from your records)	354	618	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	193.96	108.33	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	13	56	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	2,521	6,066	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		135,613			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		8,587			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0234

Period:

Worksheet M-4

Component CCN: 14-8561

From 07/01/2020
To 06/30/2021Date/Time Prepared:
1/28/2022 2:57 pm

		Title XVIII		RHC V		
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	781,785	781,785	781,785	781,785	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000768	0.002897	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	600	2,265	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	13,753	9,171	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	14,353	11,436	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	902,462	902,462	902,462	902,462	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	632,520	632,520	632,520	632,520	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.015904	0.012672	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	10,060	8,015	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	24,413	19,451	0	0	10.00
11.00	Total number of injections/infusions (from your records)	142	536	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	171.92	36.29	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	31	116	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	5,330	4,210	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		43,864			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		9,540			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0234 Component CCN: 14-8564	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 1/28/2022 2:57 pm
		RHC I		
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		71,425	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	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		05/26/2021	6,276	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		6,276	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		77,701	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			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		23,137	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		100,838	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0234 Component CCN: 14-8565	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 1/28/2022 2:57 pm
		RHC II		
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		189,831	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	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		05/26/2021	5,995	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		5,995	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		195,826	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			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		22,387	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		218,213	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0234 Component CCN: 14-8562	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 1/28/2022 2:57 pm
			RHC III	
			Part B	
			mm/dd/yyyy	Amount
			1.00	2.00
1.00	Total interim payments paid to hospital-based RHC/FQHC			804,121 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 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)			
Program to Provider				
3.01		05/26/2021	117,862	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		117,862	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		921,983	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			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)		0	6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		85,998	6.02
7.00	Total Medicare program liability (see instructions)		835,985	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00 2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0234 Component CCN: 14-8563	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 1/28/2022 2:57 pm
		RHC IV		
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		357,391	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	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		05/26/2021	21,585	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		21,585	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		378,976	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			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		90,483	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		469,459	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0234 Component CCN: 14-8561	Period: From 07/01/2020 To 06/30/2021	Worksheet M-5 Date/Time Prepared: 1/28/2022 2:57 pm
		RHC V		
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		168,015	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	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			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50		05/26/2021	1,290	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-1,290	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		166,725	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			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		78,213	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		244,938	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00