

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

OMB NO. 0938-0050

EXPIRES 03-31-2022

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

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet S
Parts I-III
Date/Time Prepared:
5/26/2022 8:33 am

PART I - COST REPORT STATUS

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

PART II - CERTIFICATION 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 07/01/2021 and ending 09/30/2021 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	2			
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title				3
4	Date				4

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-15,176	-34,237	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		37		0	10.00
10.01	RURAL HEALTH CLINIC II	0		1,723		0	10.01
10.02	RURAL HEALTH CLINIC III	0		3,087		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		3,186		0	10.03
10.04	RURAL HEALTH CLINIC V	0		3,234		0	10.04
200.00	Total	0	-15,176	-22,970	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 07/01/2021 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 8:33 am		
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	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF		SWING BED	14U234	99914		07/01/1991	N	P	N	7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC		WOMENS HEALTH CARE CENTER	148564	99914		08/22/2016	N	N	O	15.00
15.01	Hospital-Based Health Clinic - RHC II		LASALLE MEDICAL CLINIC	148565	99914		09/01/2016	N	N	O	15.01
15.02	Hospital-Based Health Clinic - RHC III		PERU MEDICAL CLINIC	148562	99914		09/08/2016	N	N	O	15.02
15.03	Hospital-Based Health Clinic - RHC IV		PERU PRIMARY CARE CLINIC	148563	99914		09/12/2016	N	N	O	15.03
15.04	Hospital-Based Health Clinic - RHC		VOGLESBY MEDICAL CLINIC	148561	99914		08/25/2016	N	N	O	15.04
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2021	09/30/2021		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	

MCRIF32 - 17.4.174.1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0234		Period: From 07/01/2021 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 8:33 am	
				V	XVIII	XIX	
				1.00	2.00	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	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00		2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						0.00
62.01	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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Part I
Date/Time Prepared:
5/26/2022 8:33 am

			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0234	Period: From 07/01/2021 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 8:33 am	
			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

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				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:	1	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0234		Period: From 07/01/2021 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 8:33 am	
				1.00			2.00		
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00	
133.00	Removed and reserved							133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00	
All Providers									
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			Y		35H002		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: SISTERS MARY OF THE PRESENTATION			Contractor's Name: NORIDIAN		Contractor's Number: 03001		141.00	
142.00	Street: 1202 PAGE DR SW PO BOX 10007			PO Box:				142.00	
143.00	City: FARGO			State: ND		Zip Code: 58106-0007		143.00	
						1.00			
144.00	Are provider based physicians' costs included in Worksheet A?					Y		144.00	
						1.00		2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N		146.00	
						1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N		149.00	
				Part A		Part B		Title V	
				1.00		2.00		3.00	
								Title XIX	
								4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N		N		N	
156.00	Subprovider - IPF			N		N		N	
157.00	Subprovider - IRF			N		N		N	
158.00	SUBPROVIDER			N		N		N	
159.00	SNF			N		N		N	
160.00	HOME HEALTH AGENCY			N		N		N	
161.00	CMHC			N		N		N	
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N		165.00	
				Name		County		State	
				0		1.00		2.00	
						3.00		4.00	
								5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.00	
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					N		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					9.99		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0234	Period: From 07/01/2021 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 5/26/2022 8:33 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0234	Period: From 07/01/2021 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 5/26/2022 8:33 am
			Y/N 1.00	Date 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 1.00	Date 2.00	V/I 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 1.00	Type 2.00	Date 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 1.00	Legal Oper. 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 1.00	Date 2.00	Y/N 3.00
				Date 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		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/11/2022	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0234

Period:
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Date/Time Prepared:
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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?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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@ABOUTSMH.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0234

Period:
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To 09/30/2021Worksheet S-2
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Date/Time Prepared:
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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

HFS Supplemental Information		Provider CCN: 14-0234	Period: From 07/01/2021 To 09/30/2021	Worksheet S-2 Part IX Date/Time Prepared: 5/26/2022 8:33 am
			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.			10.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
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Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	45	3,800	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	3,800	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	340	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	4,140	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 07/01/2021
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
5/26/2022 8:33 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	518	115	1,087		1.00
2.00	HMO and other (see instructions)	155	107			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	518	115	1,087		7.00
8.00	INTENSIVE CARE UNIT	73	0	195		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		87	151		13.00
14.00	Total (see instructions)	591	202	1,433	0.00	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	24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC	65	0	2,064	0.00	26.00
26.01	RURAL HEALTH CLINIC II	288	0	1,226	0.00	26.01
26.02	RURAL HEALTH CLINIC III	759	0	1,255	0.00	26.02
26.03	RURAL HEALTH CLINIC IV	461	0	2,357	0.00	26.03
26.04	RURAL HEALTH CLINIC V	305	0	1,415	0.00	26.04
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	27.00
28.00	Observation Bed Days		0	418		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	17	37		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 07/01/2021
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
5/26/2022 8:33 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	164	121	369	1.00
2.00 HMO and other (see instructions)			35	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation 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	164	121	369	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 07/01/2021
To 09/30/2021Worksheet S-3
Part II
Date/Time Prepared:
5/26/2022 8:33 am

	Wkst. A Line Number	Amount Reported	Reclassificat ion 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	7,313,899	0	7,313,899	257,114.08	28.45 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non Physician-Part B		2,092,571	0	2,092,571	14,991.00	139.59 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		465,905	0	465,905	18,367.30	25.37 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		337,286	-20,043	317,243	8,796.23	36.07 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		697,559	0	697,559	7,334.00	95.11 11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		225,617	0	225,617	1,398.00	161.39 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00 16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		1,585,886	0	1,585,886		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		85,313	0	85,313		
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		343,420	0	343,420		
24.00	Wage-related costs (RHC/FQHC)		147,040	0	147,040		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		41,988	0	41,988		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet S-3
Part II
Date/Time Prepared:
5/26/2022 8:33 am

		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	39,975	-2,376	37,599	1,400.34	26.85	26.00
27.00	Administrative & General	5.00	378,217	412,168	790,385	40,475.52	19.53	27.00
28.00	Administrative & General under contract (see inst.)		14,749	0	14,749	499.00	29.56	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	161,560	-9,601	151,959	9,002.33	16.88	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	9,963	-592	9,371	560.00	16.73	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	64,847	-9,379	55,468	1,878.26	29.53	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	5,525	5,525	317.59	17.40	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	168,494	-10,013	158,481	3,487.70	45.44	38.00
39.00	Central Services and Supply	14.00	35,374	-2,102	33,272	1,691.13	19.67	39.00
40.00	Pharmacy	15.00	175,936	-10,455	165,481	4,040.60	40.95	40.00
41.00	Medical Records & Medical Records Library	16.00	117,799	-7,000	110,799	7,238.50	15.31	41.00
42.00	Social Service	17.00	45,540	-2,706	42,834	1,476.00	29.02	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet S-3
Part III
Date/Time Prepared:
5/26/2022 8:33 am

	Worksheet A Line Number	Amount Reported	Reclassificat ion 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)	4,770,172	0	4,770,172	224,254.78	21.27	1.00
2.00	Excluded area salaries (see instructions)	337,286	-20,043	317,243	8,796.23	36.07	2.00
3.00	Subtotal salaries (line 1 minus line 2)	4,432,886	20,043	4,452,929	215,458.55	20.67	3.00
4.00	Subtotal other wages & related costs (see inst.)	923,176	0	923,176	8,732.00	105.72	4.00
5.00	Subtotal wage-related costs (see inst.)	1,627,874	0	1,627,874	0.00	36.56	5.00
6.00	Total (sum of lines 3 thru 5)	6,983,936	20,043	7,003,979	224,190.55	31.24	6.00
7.00	Total overhead cost (see instructions)	1,212,454	363,469	1,575,923	72,066.97	21.87	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet S-3
Part IV
Date/Time Prepared:
5/26/2022 8:33 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	442,953	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)	1,149,096	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	71,950	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	27,326	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)	33,674	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	74,439	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	511,308	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	-149,087	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,161,659	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 07/01/2021
To 09/30/2021Worksheet S-3
Part V
Date/Time Prepared:
5/26/2022 8:33 am

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	697,559	2,161,659	1.00
2.00	Hospital	697,559	1,831,161	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	101,969	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	42,034	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	61,987	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	69,869	14.03
14.04	Hospital-Based Health Clinic RHC 4	0	54,639	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 07/01/2021 To 09/30/2021		Worksheet S-8 Date/Time Prepared: 5/26/2022 8:33 am	
				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 07/01/2021 To 09/30/2021	Worksheet S-8 Date/Time Prepared: 5/26/2022 8:33 am	
			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 07/01/2021 To 09/30/2021		Worksheet S-8 Date/Time Prepared: 5/26/2022 8:33 am	
				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 07/01/2021 To 09/30/2021	Worksheet S-8 Date/Time Prepared: 5/26/2022 8:33 am	
					RHC II		
			Friday		Saturday		
			from	to	from	to	
			11.00	12.00	13.00	14.00	
Facility hours of operations (1)							
11.00	CLINIC		07:00	17:00			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0234 Component CCN: 14-8562		Period: From 07/01/2021 To 09/30/2021		Worksheet S-8 Date/Time Prepared: 5/26/2022 8:33 am	
				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?			N				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 07/01/2021 To 09/30/2021	Worksheet S-8 Date/Time Prepared: 5/26/2022 8:33 am	
					RHC III		
			Friday		Saturday		
			from	to	from	to	
			11.00	12.00	13.00	14.00	
Facility hours of operations (1)							
11.00	CLINIC		08:30	17:00			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0234 Component CCN: 14-8563		Period: From 07/01/2021 To 09/30/2021		Worksheet S-8 Date/Time Prepared: 5/26/2022 8:33 am	
				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		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		17:00		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	
				1.00		2.00		3.00	
								XIX	
								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 to	
				6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)									
11.00	CLINIC				17:00		08:00		17:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0234 Component CCN: 14-8563		Period: From 07/01/2021 To 09/30/2021		Worksheet S-8 Date/Time Prepared: 5/26/2022 8:33 am	
						RHC IV			
				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: 14-8561		Period: From 07/01/2021 To 09/30/2021		Worksheet S-8 Date/Time Prepared: 5/26/2022 8:33 am	
				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	
						1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban							0	
				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	
				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	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							14.00	
				Y/N		V		XVIII	
				1.00		2.00		3.00	
								XIX	
								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 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	
								11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0234 Component CCN: 14-8561	Period: From 07/01/2021 To 09/30/2021	Worksheet S-8 Date/Time Prepared: 5/26/2022 8:33 am	
			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 UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0234	Period: From 07/01/2021 To 09/30/2021	Worksheet S-10 Date/Time Prepared: 5/26/2022 8:33 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.297144 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	1,348,482		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	8,222,684		6.00
7.00	Medicaid cost (line 1 times line 6)	2,443,321		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)	1,094,839		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)	1,094,839		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)	9,466	14,430	23,896 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,813	14,430	17,243 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)	2,813	14,430	17,243 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)	1,773,921		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	6,754		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	10,391		27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,763,530		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	527,659		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	544,902		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,639,741		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet A

Date/Time Prepared:
5/26/2022 8:33 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		267,721	267,721	21,690	289,411	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		303,336	303,336	347,101	650,437	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	39,975	2,143,660	2,183,635	-2,376	2,181,259	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	378,217	4,546,989	4,925,206	305,786	5,230,992	5.00
7.00	00700	OPERATION OF PLANT	161,560	584,295	745,855	-11,175	734,680	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	47,222	47,222	0	47,222	8.00
9.00	00900	HOUSEKEEPING	9,963	467,833	477,796	-592	477,204	9.00
10.00	01000	DIETARY	64,847	249,208	314,055	-160,022	154,033	10.00
11.00	01100	CAFETERIA	0	0	0	156,168	156,168	11.00
13.00	01300	NURSING ADMINISTRATION	168,494	13,576	182,070	-10,013	172,057	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	35,374	39,824	75,198	-28,774	46,424	14.00
15.00	01500	PHARMACY	175,936	99,549	275,485	-30,197	245,288	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	117,799	113,981	231,780	-7,000	224,780	16.00
17.00	01700	SOCIAL SERVICE	45,540	1,276	46,816	-2,706	44,110	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,065,401	272,088	1,337,489	-259,492	1,077,997	30.00
31.00	03100	INTENSIVE CARE UNIT	165,964	125,844	291,808	-9,863	281,945	31.00
43.00	04300	NURSERY	0	0	0	97,323	97,323	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	174,870	1,618,142	1,793,012	-680,124	1,112,888	50.00
50.01	05001	SAME DAY SURGERY	119,598	10,940	130,538	-7,107	123,431	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	64,813	85,930	150,743	-32,542	118,201	50.03
51.00	05100	RECOVERY ROOM	46,188	1,378	47,566	-2,745	44,821	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	98,045	98,045	52.00
53.00	05300	ANESTHESIOLOGY	158,074	470,265	628,339	-9,788	618,551	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	339,267	618,407	957,674	-92,306	865,368	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	196,579	707,252	903,831	-11,999	891,832	60.00
64.00	06400	INTRAVENOUS THERAPY	52,937	4,872	57,809	-3,146	54,663	64.00
65.00	06500	RESPIRATORY THERAPY	97,608	64,577	162,185	-34,772	127,413	65.00
66.00	06600	PHYSICAL THERAPY	303,038	97,260	400,298	-87,513	312,785	66.00
67.00	06700	OCCUPATIONAL THERAPY	35,736	111	35,847	-2,124	33,723	67.00
68.00	06800	SPEECH PATHOLOGY	14,453	0	14,453	-859	13,594	68.00
69.00	06900	ELECTROCARDIOLOGY	40,871	34,143	75,014	-2,429	72,585	69.00
69.02	06902	CARDIAC REHAB	33,632	864	34,496	-1,999	32,497	69.02
69.03	06903	WOUND CARE	0	3,995	3,995	-919	3,076	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	19,825	190	20,015	-1,178	18,837	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	76,356	76,356	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	559,331	559,331	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	601,910	601,910	0	601,910	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	436,065	250,272	686,337	-25,914	660,423	88.00
88.01	08801	RURAL HEALTH CLINIC II	160,924	43,818	204,742	-9,563	195,179	88.01
88.02	08802	RURAL HEALTH CLINIC III	264,353	49,379	313,732	-28,814	284,918	88.02
88.03	08803	RURAL HEALTH CLINIC IV	300,141	126,437	426,578	-17,836	408,742	88.03
88.04	08804	RURAL HEALTH CLINIC V	217,472	80,415	297,887	-12,924	284,963	88.04
90.00	09000	CLINIC	1,040,231	513,365	1,553,596	-49,002	1,504,594	90.00
91.00	09100	EMERGENCY	430,868	834,666	1,265,534	-55,633	1,209,901	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	13,855	3,827	17,682	-823	16,859	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		249,998	249,998	0	249,998	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	0	4,622	4,622	-4,622	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,990,468	15,753,437	22,743,905	-37,091	22,706,814	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	67,002	10,640	77,642	-2,435	75,207	192.02
192.03	19203	OCCUPATIONAL MEDICINE	78,086	19,676	97,762	-4,640	93,122	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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet A

Date/Time Prepared:
5/26/2022 8:33 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
192.11	19211	FAST CARE	0	3	3	0	3	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	105,355	39,858	145,213	-18,261	126,952	192.16
192.17	19217	STREATOR ORTHO CLINIC	0	432	432	0	432	192.17
194.00	07950	OTHER PHYSICIANS OFFICES	72,988	2,631	75,619	62,427	138,046	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	7,313,899	15,826,677	23,140,576	0	23,140,576	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet A

Date/Time Prepared:
5/26/2022 8:33 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	289,411	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-761	649,676	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-203,282	1,977,977	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,540,473	2,690,519	5.00
7.00	00700	OPERATION OF PLANT	-6,929	727,751	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	47,222	8.00
9.00	00900	HOUSEKEEPING	0	477,204	9.00
10.00	01000	DIETARY	-7,372	146,661	10.00
11.00	01100	CAFETERIA	-12,002	144,166	11.00
13.00	01300	NURSING ADMINISTRATION	-400	171,657	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	46,424	14.00
15.00	01500	PHARMACY	0	245,288	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-68	224,712	16.00
17.00	01700	SOCIAL SERVICE	0	44,110	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-421,888	656,109	30.00
31.00	03100	INTENSIVE CARE UNIT	-7,200	274,745	31.00
43.00	04300	NURSERY	0	97,323	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,112,888	50.00
50.01	05001	SAME DAY SURGERY	0	123,431	50.01
50.02	05002	LITHOTRIPSY	0	0	50.02
50.03	05003	ENDOSCOPY	0	118,201	50.03
51.00	05100	RECOVERY ROOM	0	44,821	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	98,045	52.00
53.00	05300	ANESTHESIOLOGY	-523,519	95,032	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-150	865,218	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-2,721	889,111	60.00
64.00	06400	INTRAVENOUS THERAPY	0	54,663	64.00
65.00	06500	RESPIRATORY THERAPY	0	127,413	65.00
66.00	06600	PHYSICAL THERAPY	0	312,785	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	33,723	67.00
68.00	06800	SPEECH PATHOLOGY	0	13,594	68.00
69.00	06900	ELECTROCARDIOLOGY	-21,526	51,059	69.00
69.02	06902	CARDIAC REHAB	0	32,497	69.02
69.03	06903	WOUND CARE	0	3,076	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	18,837	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	76,356	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	559,331	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	601,910	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-132,342	528,081	88.00
88.01	08801	RURAL HEALTH CLINIC II	-7,701	187,478	88.01
88.02	08802	RURAL HEALTH CLINIC III	-4,290	280,628	88.02
88.03	08803	RURAL HEALTH CLINIC IV	-9,000	399,742	88.03
88.04	08804	RURAL HEALTH CLINIC V	-12,500	272,463	88.04
90.00	09000	CLINIC	-894,839	609,755	90.00
91.00	09100	EMERGENCY	-672,619	537,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	16,859	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-249,998	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,731,580	16,975,234	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	75,207	192.02
192.03	19203	OCCUPATIONAL MEDICINE	0	93,122	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	0	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	3	192.11

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet A

Date/Time Prepared:
5/26/2022 8:33 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
192.12	19212	IVCH CARE TODAY	0	0	192.12
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	126,952	192.16
192.17	19217	STREATOR ORTHO CLINIC	0	432	192.17
194.00	07950	OTHER PHYSICIANS OFFICES	0	138,046	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,731,580	17,408,996	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet Non-CMS W

Date/Time Prepared:
5/26/2022 8:33 am

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 07/01/2021
To 09/30/2021

Worksheet Non-CMS W

Date/Time Prepared:
5/26/2022 8:33 am

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 07/01/2021
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
5/26/2022 8:33 am

	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	21,690		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,303		2.00
	TOTALS		0	28,993		
	B - CAFETERIA/MOW COSTS					
1.00	CAFETERIA	11.00	5,874	150,643		1.00
	TOTALS		5,874	150,643		
	C - RENTALS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	339,798		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
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
	TOTALS		0	339,798		
	D - IMPLANTABLE SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	559,331		1.00
	TOTALS		0	559,331		
	E - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	76,356		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
	TOTALS		0	76,356		
	F - PUBLIC RELATIONS					
1.00	OTHER PHYSICIANS OFFICES	194.00	0	66,764		1.00
	TOTALS		0	66,764		
	G - RECLASS PMC MIDLEVEL SALARIES					
1.00	CLINIC	90.00	12,816	0		1.00
2.00	EMERGENCY	91.00	288	0		2.00
	TOTALS		13,104	0		
	H - NURSEY AND LABOR&DELIVERY					
1.00	NURSERY	43.00	95,258	7,726		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	95,965	7,783		2.00
	TOTALS		191,223	15,509		
	J - HOSPICE					
1.00	COMMUNITY HEALTH	192.02	0	4,622		1.00
	TOTALS		0	4,622		
	K - ALLOCATE SALARIES					
1.00	ADMINISTRATIVE & GENERAL	5.00	462,106	0		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
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
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
5/26/2022 8:33 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
38.00		0.00	0	0		38.00
39.00		0.00	0	0		39.00
40.00		0.00	0	0		40.00
41.00		0.00	0	0		41.00
42.00		0.00	0	0		42.00
	TOTALS		462,106	0		
500.00	Grand Total: Increases		672,307	1,242,016		500.00

RECLASSIFICATIONS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
5/26/2022 8:33 am

		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	A - PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	28,993	12		1.00	
2.00		0.00	0	0	12		2.00	
	TOTALS		0	28,993				
	B - CAFETERIA/MOW COSTS							
1.00	DIETARY	10.00	5,874	150,643	0		1.00	
	TOTALS		5,874	150,643				
	C - RENTALS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,625	10		1.00	
2.00	OPERATION OF PLANT	7.00	0	1,574	0		2.00	
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	69	0		3.00	
4.00	PHARMACY	15.00	0	19,742	0		4.00	
5.00	ADULTS & PEDIATRICS	30.00	0	810	0		5.00	
6.00	OPERATING ROOM	50.00	0	110,401	0		6.00	
7.00	ENDOSCOPY	50.03	0	28,690	0		7.00	
8.00	ANESTHESIOLOGY	53.00	0	394	0		8.00	
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	72,144	0		9.00	
10.00	LABORATORY	60.00	0	317	0		10.00	
11.00	RESPIRATORY THERAPY	65.00	0	12,749	0		11.00	
12.00	PHYSICAL THERAPY	66.00	0	66,289	0		12.00	
13.00	WOUND CARE	69.03	0	919	0		13.00	
14.00	COMMUNITY HEALTH	192.02	0	3,075	0		14.00	
15.00	STREATOR MEDICAL CLINIC	192.16	0	12,000	0		15.00	
	TOTALS		0	339,798				
	D - IMPLANTABLE SUPPLIES							
1.00	OPERATING ROOM	50.00	0	559,331	0		1.00	
	TOTALS		0	559,331				
	E - MEDICAL SUPPLIES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	26,603	0		1.00	
2.00	RESPIRATORY THERAPY	65.00	0	16,222	0		2.00	
3.00	PHYSICAL THERAPY	66.00	0	3,215	0		3.00	
4.00	EMERGENCY	91.00	0	30,316	0		4.00	
	TOTALS		0	76,356				
	F - PUBLIC RELATIONS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	66,764	0		1.00	
	TOTALS		0	66,764				
	G - RECLASS PMC MIDLEVEL SALARIES							
1.00	RURAL HEALTH CLINIC III	88.02	13,104	0	0		1.00	
2.00		0.00	0	0	0		2.00	
	TOTALS		13,104	0				
	H - NURSEY AND LABOR&DELIVERY							
1.00	ADULTS & PEDIATRICS	30.00	191,223	15,509	0		1.00	
2.00		0.00	0	0	0		2.00	
	TOTALS		191,223	15,509				
	J - HOSPICE							
1.00	HOSPICE	116.00	0	4,622	0		1.00	
	TOTALS		0	4,622				
	K - ALLOCATE SALARIES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2,376	0	0		1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	49,938	0	0		2.00	
3.00	OPERATION OF PLANT	7.00	9,601	0	0		3.00	
4.00	HOUSEKEEPING	9.00	592	0	0		4.00	
5.00	DIETARY	10.00	3,505	0	0		5.00	
6.00	CAFETERIA	11.00	349	0	0		6.00	
7.00	NURSING ADMINISTRATION	13.00	10,013	0	0		7.00	
8.00	CENTRAL SERVICES & SUPPLY	14.00	2,102	0	0		8.00	
9.00	PHARMACY	15.00	10,455	0	0		9.00	
10.00	MEDICAL RECORDS & LIBRARY	16.00	7,000	0	0		10.00	
11.00	SOCIAL SERVICE	17.00	2,706	0	0		11.00	
12.00	ADULTS & PEDIATRICS	30.00	51,950	0	0		12.00	
13.00	INTENSIVE CARE UNIT	31.00	9,863	0	0		13.00	
14.00	NURSERY	43.00	5,661	0	0		14.00	
15.00	OPERATING ROOM	50.00	10,392	0	0		15.00	
16.00	SAME DAY SURGERY	50.01	7,107	0	0		16.00	
17.00	ENDOSCOPY	50.03	3,852	0	0		17.00	
18.00	RECOVERY ROOM	51.00	2,745	0	0		18.00	
19.00	DELIVERY ROOM & LABOR ROOM	52.00	5,703	0	0		19.00	
20.00	ANESTHESIOLOGY	53.00	9,394	0	0		20.00	
21.00	RADIOLOGY-DIAGNOSTIC	54.00	20,162	0	0		21.00	
22.00	LABORATORY	60.00	11,682	0	0		22.00	
23.00	INTRAVENOUS THERAPY	64.00	3,146	0	0		23.00	
24.00	RESPIRATORY THERAPY	65.00	5,801	0	0		24.00	
25.00	PHYSICAL THERAPY	66.00	18,009	0	0		25.00	
26.00	OCCUPATIONAL THERAPY	67.00	2,124	0	0		26.00	

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet A-6
Date/Time Prepared:
5/26/2022 8:33 am

	Decreases						07/20/2022 07:00 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
27.00	SPEECH PATHOLOGY	68.00	859	0	0		27.00
28.00	ELECTROCARDIOLOGY	69.00	2,429	0	0		28.00
29.00	CARDIAC REHAB	69.02	1,999	0	0		29.00
30.00	ELECTROENCEPHALOGRAPHY	70.00	1,178	0	0		30.00
31.00	RURAL HEALTH CLINIC	88.00	25,914	0	0		31.00
32.00	RURAL HEALTH CLINIC II	88.01	9,563	0	0		32.00
33.00	RURAL HEALTH CLINIC III	88.02	15,710	0	0		33.00
34.00	RURAL HEALTH CLINIC IV	88.03	17,836	0	0		34.00
35.00	RURAL HEALTH CLINIC V	88.04	12,924	0	0		35.00
36.00	CLINIC	90.00	61,818	0	0		36.00
37.00	EMERGENCY	91.00	25,605	0	0		37.00
38.00	AMBULANCE SERVICES	95.00	823	0	0		38.00
39.00	COMMUNITY HEALTH	192.02	3,982	0	0		39.00
40.00	OCCUPATIONAL MEDICINE	192.03	4,640	0	0		40.00
41.00	STREATOR MEDICAL CLINIC	192.16	6,261	0	0		41.00
42.00	OTHER PHYSICIANS OFFICES	194.00	4,337	0	0		42.00
	TOTALS		462,106	0			
500.00	Grand Total: Decreases		672,307	1,242,016			500.00

RECLASSIFICATIONS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
5/26/2022 8:33 am

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	21,690	ADMINISTRATIVE & GENERAL	5.00	0	28,993	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,303		0.00	0	0	2.00
	TOTALS		0	28,993	TOTALS		0	28,993	
B - CAFETERIA/MOW COSTS									
1.00	CAFETERIA	11.00	5,874	150,643	DIETARY	10.00	5,874	150,643	1.00
	TOTALS		5,874	150,643	TOTALS		5,874	150,643	
C - RENTALS									
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	339,798	ADMINISTRATIVE & GENERAL	5.00	0	10,625	1.00
2.00		0.00	0	0	OPERATION OF PLANT	7.00	0	1,574	2.00
3.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	69	3.00
4.00		0.00	0	0	PHARMACY	15.00	0	19,742	4.00
5.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	810	5.00
6.00		0.00	0	0	OPERATING ROOM	50.00	0	110,401	6.00
7.00		0.00	0	0	ENDOSCOPY	50.03	0	28,690	7.00
8.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	394	8.00
9.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	72,144	9.00
10.00		0.00	0	0	LABORATORY	60.00	0	317	10.00
11.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	12,749	11.00
12.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	66,289	12.00
13.00		0.00	0	0	WOUND CARE	69.03	0	919	13.00
14.00		0.00	0	0	COMMUNITY HEALTH	192.02	0	3,075	14.00
15.00		0.00	0	0	STREATOR MEDICAL CLINIC	192.16	0	12,000	15.00
	TOTALS		0	339,798	TOTALS		0	339,798	
D - IMPLANTABLE SUPPLIES									
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	559,331	OPERATING ROOM	50.00	0	559,331	1.00
	TOTALS		0	559,331	TOTALS		0	559,331	
E - MEDICAL SUPPLIES									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	76,356	CENTRAL SERVICES & SUPPLY	14.00	0	26,603	1.00
2.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	16,222	2.00
3.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	3,215	3.00
4.00		0.00	0	0	EMERGENCY	91.00	0	30,316	4.00
	TOTALS		0	76,356	TOTALS		0	76,356	
F - PUBLIC RELATIONS									
1.00	OTHER PHYSICIANS OFFICES	194.00	0	66,764	ADMINISTRATIVE & GENERAL	5.00	0	66,764	1.00
	TOTALS		0	66,764	TOTALS		0	66,764	
G - RECLASS PMC MIDLEVEL SALARIES									
1.00	CLINIC	90.00	12,816	0	RURAL HEALTH CLINIC III	88.02	13,104	0	1.00
2.00	EMERGENCY	91.00	288	0		0.00	0	0	2.00
	TOTALS		13,104	0	TOTALS		13,104	0	
H - NURSEY AND LABOR&DELIVERY									
1.00	NURSERY	43.00	95,258	7,726	ADULTS & PEDIATRICS	30.00	191,223	15,509	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	95,965	7,783		0.00	0	0	2.00
	TOTALS		191,223	15,509	TOTALS		191,223	15,509	
J - HOSPICE									
1.00	COMMUNITY HEALTH	192.02	0	4,622	HOSPICE	116.00	0	4,622	1.00
	TOTALS		0	4,622	TOTALS		0	4,622	
K - ALLOCATE SALARIES									
1.00	ADMINISTRATIVE & GENERAL	5.00	462,106	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	2,376	0	1.00
2.00		0.00	0	0	ADMINISTRATIVE & GENERAL	5.00	49,938	0	2.00
3.00		0.00	0	0	OPERATION OF PLANT	7.00	9,601	0	3.00
4.00		0.00	0	0	HOUSEKEEPING	9.00	592	0	4.00
5.00		0.00	0	0	DIETARY	10.00	3,505	0	5.00
6.00		0.00	0	0	CAFETERIA	11.00	349	0	6.00
7.00		0.00	0	0	NURSING	13.00	10,013	0	7.00
8.00		0.00	0	0	ADMINISTRATION				
9.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	2,102	0	8.00
10.00		0.00	0	0	PHARMACY	15.00	10,455	0	9.00
11.00		0.00	0	0	MEDICAL RECORDS & LIBRARY	16.00	7,000	0	10.00
		0.00	0	0	SOCIAL SERVICE	17.00	2,706	0	11.00

RECLASSIFICATIONS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
5/26/2022 8:33 am

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	
12.00	0.00	0			0 ADULTS & PEDIATRICS	30.00	51,950		0 12.00
13.00	0.00	0			0 INTENSIVE CARE UNIT	31.00	9,863		0 13.00
14.00	0.00	0			0 NURSERY	43.00	5,661		0 14.00
15.00	0.00	0			0 OPERATING ROOM	50.00	10,392		0 15.00
16.00	0.00	0			0 SAME DAY SURGERY	50.01	7,107		0 16.00
17.00	0.00	0			0 ENDOSCOPY	50.03	3,852		0 17.00
18.00	0.00	0			0 RECOVERY ROOM	51.00	2,745		0 18.00
19.00	0.00	0			0 DELIVERY ROOM & LABOR ROOM	52.00	5,703		0 19.00
20.00	0.00	0			0 ANESTHESIOLOGY	53.00	9,394		0 20.00
21.00	0.00	0			0 RADIOLOGY-DIAGNOSTIC	54.00	20,162		0 21.00
22.00	0.00	0			0 LABORATORY	60.00	11,682		0 22.00
23.00	0.00	0			0 INTRAVENOUS THERAPY	64.00	3,146		0 23.00
24.00	0.00	0			0 RESPIRATORY THERAPY	65.00	5,801		0 24.00
25.00	0.00	0			0 PHYSICAL THERAPY	66.00	18,009		0 25.00
26.00	0.00	0			0 OCCUPATIONAL THERAPY	67.00	2,124		0 26.00
27.00	0.00	0			0 SPEECH PATHOLOGY	68.00	859		0 27.00
28.00	0.00	0			0 ELECTROCARDIOLOGY	69.00	2,429		0 28.00
29.00	0.00	0			0 CARDIAC REHAB	69.02	1,999		0 29.00
30.00	0.00	0			0 ELECTROENCEPHALOGRAPH Y	70.00	1,178		0 30.00
31.00	0.00	0			0 RURAL HEALTH CLINIC	88.00	25,914		0 31.00
32.00	0.00	0			0 RURAL HEALTH CLINIC II	88.01	9,563		0 32.00
33.00	0.00	0			0 RURAL HEALTH CLINIC III	88.02	15,710		0 33.00
34.00	0.00	0			0 RURAL HEALTH CLINIC IV	88.03	17,836		0 34.00
35.00	0.00	0			0 RURAL HEALTH CLINIC V	88.04	12,924		0 35.00
36.00	0.00	0			0 CLINIC	90.00	61,818		0 36.00
37.00	0.00	0			0 EMERGENCY	91.00	25,605		0 37.00
38.00	0.00	0			0 AMBULANCE SERVICES	95.00	823		0 38.00
39.00	0.00	0			0 COMMUNITY HEALTH	192.02	3,982		0 39.00
40.00	0.00	0			0 OCCUPATIONAL MEDICINE	192.03	4,640		0 40.00
41.00	0.00	0			0 STREATOR MEDICAL CLINIC	192.16	6,261		0 41.00
42.00	0.00	0			0 OTHER PHYSICIANS OFFICES	194.00	4,337		0 42.00
TOTALS		462,106			TOTALS		462,106		0
500.00	Grand Total: Increases		672,307	1,242,016	Grand Total: Decreases		672,307	1,242,016	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet A-7
Part I
Date/Time Prepared:
5/26/2022 8:33 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	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	53,844,784	0	0	0	0	3.00
4.00	Building Improvements	325,067	0	0	0	0	4.00
5.00	Fixed Equipment	14,533,683	0	0	0	0	5.00
6.00	Movable Equipment	46,233,273	172,912	0	172,912	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	117,769,862	172,912	0	172,912	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	117,769,862	172,912	0	172,912	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	46,406,185	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	117,942,774	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	117,942,774	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet A-7
Part II
Date/Time Prepared:
5/26/2022 8:33 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	267,721	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	303,336	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	571,057	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	267,721				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	303,336				2.00
3.00	Total (sum of lines 1-2)	0	571,057				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet A-7
Part III
Date/Time Prepared:
5/26/2022 8:33 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	71,536,589	0	71,536,589	0.607427	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	46,233,273	0	46,233,273	0.392573	0	2.00
3.00	Total (sum of lines 1-2)	117,769,862	0	117,769,862	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	267,721	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	302,575	339,798	2.00
3.00	Total (sum of lines 1-2)	0	0	0	570,296	339,798	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	21,690	0	0	289,411	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	7,303	0	0	649,676	2.00
3.00	Total (sum of lines 1-2)	0	28,993	0	0	939,087	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet A-8

Date/Time Prepared:
5/26/2022 8:33 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-7,857	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-9,915	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,775	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)	B	-1,181	OPERATION OF PLANT	7.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,630,676			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-150	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	2,913			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-12,002	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	-68	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

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet A-8

Date/Time Prepared:
5/26/2022 8:33 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
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	-3,928	OPERATION OF PLANT	7.00	0	33.01
33.02	OTHER REVENUE - EDUCATION	B	-400	NURSING ADMINISTRATION	13.00	0	33.02
33.03	PHYSICIAN BILLING	A	-26,382	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	AHA/IHA LOBBYING	A	-5,619	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.05
33.06	NUTRITIONAL SUPPOR	B	-7,372	DIETARY	10.00	0	33.06
33.07	INTEREST EXPENSE	A	-249,998	INTEREST EXPENSE	113.00	9	33.07
33.08	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.08
33.09	MISCELLANEOUS REV	B	-649	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	TV OPERATING COSTS	A	-1,820	OPERATION OF PLANT	7.00	0	33.10
33.11	TV DEPR	A	-2,274	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.11
33.12	457B EXPENSE	A	-241,365	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	NON-RHC EXPENSES	A	-117,342	RURAL HEALTH CLINIC	88.00	0	33.13
33.14	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.14
33.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.15
33.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.16
33.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.17
33.18	RENTAL INCOME - LAS PHY OFF	B	-7,701	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	-14,280	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	-4,290	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	-15,000	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	-7,200	CLINIC	90.00	0	33.26
33.27	RENTAL INCOME - SLEEP CLINIC	B	-2,700	CLINIC	90.00	0	33.27
33.28	RENTAL INCOME - PPCC	B	-9,000	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	-12,500	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	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.32
33.33	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.33
33.34	HOSPITALIST	B	-21,422	ADULTS & PEDIATRICS	30.00	0	33.34
33.35	MANAGEMENT FEES	B	-15,000	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.36
33.37	NON-OP REV/EXP - MISC REV/(EXP)	B	-6,000	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38	NON ALLOWABLE EXPENSE	A	-1,451,790	ADMINISTRATIVE & GENERAL	5.00	0	33.38
33.39	MEDICAID ASSESSMENT	A	-775,521	ADMINISTRATIVE & GENERAL	5.00	0	33.39
33.40	CBO	B	-71,316	CLINIC	90.00	0	33.40
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,731,580				50.00

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

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet A-8-1

Date/Time Prepared:
5/26/2022 8:33 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.00	ADMINISTRATIVE & GENERAL	MGMT FEE	283,295	281,895	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	OLD CAPITAL	14	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL	1,499	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			284,808	281,895	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
				Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	B		0.00	SISTER OF MARY	100.00	6.00
7.00	B		0.00	SISTER OF MARY	100.00	7.00
8.00	B		0.00	SISTER OF MARY	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet A-8-1

Date/Time Prepared:
5/26/2022 8:33 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	1,400	0		1.00
2.00	14	9		2.00
3.00	1,499	9		3.00
4.00	0	0		4.00
5.00	2,913			5.00

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

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

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

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

6.00	RELIGIOUS COMM.		6.00
7.00	RELIGIOUS COMM.		7.00
8.00	RELIGIOUS COMM.		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet A-8-2

Date/Time Prepared:
5/26/2022 8:33 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	305,060	305,060	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	102,760	102,760	0	0	0	2.00
3.00	90.00	CLINIC	771,701	771,701	0	0	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	203,282	203,282	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	95,406	95,406	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	7,200	7,200	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	420,759	420,759	0	0	0	7.00
8.00	60.00	LABORATORY	2,721	2,721	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	21,526	21,526	0	0	0	10.00
11.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	11.00
12.00	90.00	CLINIC	27,642	27,642	0	0	0	12.00
13.00	91.00	EMERGENCY	672,619	672,619	0	0	0	13.00
200.00			2,630,676	2,630,676	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	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
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	305,060		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	102,760		2.00
3.00	90.00	CLINIC	0	0	0	771,701		3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	203,282		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	95,406		5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	7,200		6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	420,759		7.00
8.00	60.00	LABORATORY	0	0	0	2,721		8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	0		9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	21,526		10.00
11.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0		11.00
12.00	90.00	CLINIC	0	0	0	27,642		12.00
13.00	91.00	EMERGENCY	0	0	0	672,619		13.00
200.00			0	0	0	2,630,676		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
5/26/2022 8:33 am

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	289,411	289,411			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	649,676		649,676		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,977,977	1,176	2,568	1,981,721	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,690,519	47,742	104,275	113,180	5.00
7.00	00700	OPERATION OF PLANT	727,751	44,076	96,272	53,509	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	47,222	5,018	10,960	0	8.00
9.00	00900	HOUSEKEEPING	477,204	3,375	7,372	3,300	9.00
10.00	01000	DIETARY	146,661	5,632	12,301	19,532	10.00
11.00	01100	CAFETERIA	144,166	3,288	7,182	1,946	11.00
13.00	01300	NURSING ADMINISTRATION	171,657	1,858	4,058	55,806	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	46,424	3,649	7,970	11,716	14.00
15.00	01500	PHARMACY	245,288	1,718	3,752	58,271	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	224,712	2,295	5,012	39,016	16.00
17.00	01700	SOCIAL SERVICE	44,110	588	1,284	15,083	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	656,109	42,324	92,446	182,110	30.00
31.00	03100	INTENSIVE CARE UNIT	274,745	4,691	10,247	54,968	31.00
43.00	04300	NURSERY	97,323	0	0	31,550	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,112,888	11,189	24,439	57,918	50.00
50.01	05001	SAME DAY SURGERY	123,431	4,237	9,254	39,611	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	118,201	0	0	21,466	50.03
51.00	05100	RECOVERY ROOM	44,821	1,177	2,571	15,298	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	98,045	0	0	31,784	52.00
53.00	05300	ANESTHESIOLOGY	95,032	2,907	6,350	16,170	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	865,218	10,925	23,862	112,366	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	889,111	4,736	10,345	65,108	60.00
64.00	06400	INTRAVENOUS THERAPY	54,663	5,483	11,977	17,533	64.00
65.00	06500	RESPIRATORY THERAPY	127,413	2,156	4,709	32,328	65.00
66.00	06600	PHYSICAL THERAPY	312,785	6,451	14,091	100,367	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,723	0	0	11,836	67.00
68.00	06800	SPEECH PATHOLOGY	13,594	0	0	4,787	68.00
69.00	06900	ELECTROCARDIOLOGY	51,059	729	1,593	13,537	69.00
69.02	06902	CARDIAC REHAB	32,497	4,728	10,327	11,139	69.02
69.03	06903	WOUND CARE	3,076	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	18,837	110	241	6,566	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	76,356	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	559,331	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	601,910	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	528,081	9,953	21,740	144,426	88.00
88.01	08801	RURAL HEALTH CLINIC II	187,478	0	8,621	53,299	88.01
88.02	08802	RURAL HEALTH CLINIC III	280,628	4,900	10,702	82,940	88.02
88.03	08803	RURAL HEALTH CLINIC IV	399,742	5,662	12,367	99,408	88.03
88.04	08804	RURAL HEALTH CLINIC V	272,463	0	8,918	72,027	88.04
90.00	09000	CLINIC	609,755	12,282	26,826	77,302	90.00
91.00	09100	EMERGENCY	537,282	4,467	9,756	142,807	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	16,859	57	125	4,589	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	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,975,234	259,579	584,513	1,874,599	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	446	975	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	MOB	0	28,993	63,328	0	192.01
192.02	19202	COMMUNITY HEALTH	75,207	0	0	22,191	192.02
192.03	19203	OCCUPATIONAL MEDICINE	93,122	219	479	25,863	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	174	381	0	192.08

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
5/26/2022 8:33 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
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	3	0	0	0	3	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	126,952	0	0	34,894	161,846	192.16
192.17	19217	STREATOR ORTHO CLINIC	432	0	0	0	432	192.17
194.00	07950	OTHER PHYSICIANS OFFICES	138,046	0	0	24,174	162,220	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)	17,408,996	289,411	649,676	1,981,721	17,408,996	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
5/26/2022 8:33 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,955,716					5.00
7.00	00700	OPERATION OF PLANT	188,470	1,110,078				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,924	28,360	104,484			8.00
9.00	00900	HOUSEKEEPING	100,461	19,076	0	610,788		9.00
10.00	01000	DIETARY	37,654	31,829	0	15,090	268,699	10.00
11.00	01100	CAFETERIA	32,021	18,583	0	0	139,857	11.00
13.00	01300	NURSING ADMINISTRATION	47,726	10,499	0	2,695	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,266	20,622	474	12,575	0	14.00
15.00	01500	PHARMACY	63,197	9,707	0	4,311	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	55,427	12,968	0	3,234	0	16.00
17.00	01700	SOCIAL SERVICE	12,488	3,323	0	539	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	198,977	239,201	50,479	179,463	54,167	30.00
31.00	03100	INTENSIVE CARE UNIT	70,481	26,514	7,731	15,809	9,399	31.00
43.00	04300	NURSERY	26,355	0	415	14,012	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	246,723	63,235	10,865	68,983	0	50.00
50.01	05001	SAME DAY SURGERY	36,101	23,945	8,269	48,324	0	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	28,562	0	0	5,389	0	50.03
51.00	05100	RECOVERY ROOM	13,061	6,653	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,550	0	404	13,653	0	52.00
53.00	05300	ANESTHESIOLOGY	24,634	16,430	403	7,365	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	207,031	61,742	9,536	15,988	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	198,223	26,768	43	12,216	0	60.00
64.00	06400	INTRAVENOUS THERAPY	18,335	30,990	309	7,545	0	64.00
65.00	06500	RESPIRATORY THERAPY	34,071	12,184	730	8,623	0	65.00
66.00	06600	PHYSICAL THERAPY	88,691	36,459	0	3,773	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,317	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,759	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	13,685	4,123	844	4,132	0	69.00
69.02	06902	CARDIAC REHAB	12,002	26,721	0	7,186	0	69.02
69.03	06903	WOUND CARE	629	0	327	15,449	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	5,267	623	0	2,695	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,615	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	114,384	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	123,091	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	144,010	56,250	1,465	26,228	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	51,002	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	77,541	27,691	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	105,764	31,998	0	16,168	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	72,272	0	0	0	0	88.04
90.00	09000	CLINIC	148,501	69,411	0	49,402	0	90.00
91.00	09100	EMERGENCY	141,987	25,245	9,524	26,947	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	4,423	323	2,627	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	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,825,678	941,473	104,445	587,794	203,423	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	291	2,523	0	0	11,205	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MOB	18,880	163,859	0	0	0	192.01
192.02	19202	COMMUNITY HEALTH	19,918	0	0	539	0	192.02
192.03	19203	OCCUPATIONAL MEDICINE	24,475	1,238	0	8,982	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	113	985	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	1	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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE E & 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	33,098	0	0	0	0	192.16
192.17	19217	STREATOR ORTHO CLINIC	88	0	0	0	0	192.17
194.00	07950	OTHER PHYSICIANS OFFICES	33,174	0	39	13,473	54,071	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)	2,955,716	1,110,078	104,484	610,788	268,699	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part I
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5/26/2022 8:33 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	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	347,043					11.00
13.00	01300	NURSING ADMINISTRATION	6,504	300,803				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,154	0	120,850			14.00
15.00	01500	PHARMACY	7,529	0	0	393,773		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,486	0	0	0	356,150	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	55,914	62,371	0	0	11,292	30.00
31.00	03100	INTENSIVE CARE UNIT	13,691	31,600	0	0	5,460	31.00
43.00	04300	NURSERY	8,564	19,755	0	0	3,571	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,763	29,467	0	0	39,806	50.00
50.01	05001	SAME DAY SURGERY	9,599	22,146	0	0	2,973	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	10,097	23,295	0	0	7,477	50.03
51.00	05100	RECOVERY ROOM	5,117	11,815	0	0	4,754	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,623	19,901	0	0	3,598	52.00
53.00	05300	ANESTHESIOLOGY	5,078	9,080	0	0	8,579	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,006	0	0	0	77,901	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	13,915	0	0	0	61,419	60.00
64.00	06400	INTRAVENOUS THERAPY	2,676	6,181	0	0	2,409	64.00
65.00	06500	RESPIRATORY THERAPY	9,043	0	0	0	2,666	65.00
66.00	06600	PHYSICAL THERAPY	17,714	5,695	0	0	8,855	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,699	0	0	0	1,060	67.00
68.00	06800	SPEECH PATHOLOGY	908	0	0	0	848	68.00
69.00	06900	ELECTROCARDIOLOGY	4,687	0	0	0	6,026	69.00
69.02	06902	CARDIAC REHAB	1,933	0	0	0	1,356	69.02
69.03	06903	WOUND CARE	0	0	0	0	2,788	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	1,221	0	0	0	1,207	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	14,516	0	3,093	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	106,334	0	10,847	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	393,773	32,902	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	17,704	0	0	0	6,219	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	1,732	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	2,312	88.02
88.03	08803	RURAL HEALTH CLINIC IV	12,060	0	0	0	4,674	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	2,890	88.04
90.00	09000	CLINIC	33,182	0	0	0	11,210	90.00
91.00	09100	EMERGENCY	25,780	59,497	0	0	26,197	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,045	0	0	0	29	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	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	331,692	300,803	120,850	393,773	356,150	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	1,719	0	0	0	0	192.02
192.03	19203	OCCUPATIONAL MEDICINE	4,824	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
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

Provider CCN: 14-0234

Period:
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Part I
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	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	5,361	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	3,447	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)	347,043	300,803	120,850	393,773	356,150	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part I
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5/26/2022 8:33 am

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	77,415				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	65,640	1,890,493	0	1,890,493	30.00
31.00	03100	INTENSIVE CARE UNIT	11,775	537,111	0	537,111	31.00
43.00	04300	NURSERY	0	201,545	0	201,545	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,678,276	0	1,678,276	50.00
50.01	05001	SAME DAY SURGERY	0	327,890	0	327,890	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	0	214,487	0	214,487	50.03
51.00	05100	RECOVERY ROOM	0	105,267	0	105,267	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	202,558	0	202,558	52.00
53.00	05300	ANESTHESIOLOGY	0	192,028	0	192,028	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,412,575	0	1,412,575	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	1,281,884	0	1,281,884	60.00
64.00	06400	INTRAVENOUS THERAPY	0	158,101	0	158,101	64.00
65.00	06500	RESPIRATORY THERAPY	0	233,923	0	233,923	65.00
66.00	06600	PHYSICAL THERAPY	0	594,881	0	594,881	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	57,635	0	57,635	67.00
68.00	06800	SPEECH PATHOLOGY	0	23,896	0	23,896	68.00
69.00	06900	ELECTROCARDIOLOGY	0	100,415	0	100,415	69.00
69.02	06902	CARDIAC REHAB	0	107,889	0	107,889	69.02
69.03	06903	WOUND CARE	0	22,269	0	22,269	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	36,767	0	36,767	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	109,580	0	109,580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	790,896	0	790,896	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,151,676	0	1,151,676	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	956,076	0	956,076	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	302,132	0	302,132	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	486,714	0	486,714	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	687,843	0	687,843	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	428,570	0	428,570	88.04
90.00	09000	CLINIC	0	1,037,871	0	1,037,871	90.00
91.00	09100	EMERGENCY	0	1,009,489	0	1,009,489	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	30,077	0	30,077	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	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,415	16,370,814	0	16,370,814	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,440	0	15,440	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	MOB	0	275,060	0	275,060	192.01
192.02	19202	COMMUNITY HEALTH	0	119,574	0	119,574	192.02
192.03	19203	OCCUPATIONAL MEDICINE	0	159,202	0	159,202	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	1,653	0	1,653	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 07/01/2021
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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	4	0	4		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	200,305	0	200,305		192.16
192.17	19217	STREATOR ORTHO CLINIC	0	520	0	520		192.17
194.00	07950	OTHER PHYSICIANS OFFICES	0	266,424	0	266,424		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)	77,415	17,408,996	0	17,408,996		202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet Non-CMS W

Date/Time Prepared:
5/26/2022 8:33 am

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	SQUARE FEET	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 07/01/2021
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
5/26/2022 8:33 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,176	2,568	3,744	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	47,742	104,275	152,017	5.00
7.00	00700	OPERATION OF PLANT	0	44,076	96,272	140,348	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,018	10,960	15,978	8.00
9.00	00900	HOUSEKEEPING	0	3,375	7,372	10,747	9.00
10.00	01000	DIETARY	0	5,632	12,301	17,933	10.00
11.00	01100	CAFETERIA	0	3,288	7,182	10,470	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,858	4,058	5,916	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,649	7,970	11,619	14.00
15.00	01500	PHARMACY	0	1,718	3,752	5,470	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,295	5,012	7,307	16.00
17.00	01700	SOCIAL SERVICE	0	588	1,284	1,872	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	42,324	92,446	134,770	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,691	10,247	14,938	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	11,189	24,439	35,628	50.00
50.01	05001	SAME DAY SURGERY	0	4,237	9,254	13,491	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	0	0	0	0	50.03
51.00	05100	RECOVERY ROOM	0	1,177	2,571	3,748	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,907	6,350	9,257	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,925	23,862	34,787	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	4,736	10,345	15,081	60.00
64.00	06400	INTRAVENOUS THERAPY	0	5,483	11,977	17,460	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,156	4,709	6,865	65.00
66.00	06600	PHYSICAL THERAPY	0	6,451	14,091	20,542	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	0	729	1,593	2,322	69.00
69.02	06902	CARDIAC REHAB	0	4,728	10,327	15,055	69.02
69.03	06903	WOUND CARE	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	110	241	351	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	0	9,953	21,740	31,693	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	8,621	8,621	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	4,900	10,702	15,602	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	5,662	12,367	18,029	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	8,918	8,918	88.04
90.00	09000	CLINIC	0	12,282	26,826	39,108	90.00
91.00	09100	EMERGENCY	0	4,467	9,756	14,223	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	57	125	182	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	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	259,579	584,513	844,092	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	446	975	1,421	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	MOB	0	28,993	63,328	92,321	192.01
192.02	19202	COMMUNITY HEALTH	0	0	0	0	192.02
192.03	19203	OCCUPATIONAL MEDICINE	0	219	479	698	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	174	381	555	192.08
192.09	19209	UTICA MEDICAL CENTER	0	0	0	0	192.09

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet B
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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	66	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	46	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	289,411	649,676	939,087	3,744	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet B
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Cost Center Description			ADMINISTRATIVE E & 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	152,231					5.00
7.00	00700	OPERATION OF PLANT	9,707	150,156				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	666	3,836	20,480			8.00
9.00	00900	HOUSEKEEPING	5,174	2,580	0	18,507		9.00
10.00	01000	DIETARY	1,939	4,305	0	457	24,671	10.00
11.00	01100	CAFETERIA	1,649	2,514	0	0	12,841	11.00
13.00	01300	NURSING ADMINISTRATION	2,458	1,420	0	82	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	735	2,789	93	381	0	14.00
15.00	01500	PHARMACY	3,255	1,313	0	131	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,855	1,754	0	98	0	16.00
17.00	01700	SOCIAL SERVICE	643	449	0	16	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,248	32,356	9,895	5,439	4,973	30.00
31.00	03100	INTENSIVE CARE UNIT	3,630	3,586	1,515	479	863	31.00
43.00	04300	NURSERY	1,357	0	81	425	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,705	8,553	2,130	2,090	0	50.00
50.01	05001	SAME DAY SURGERY	1,859	3,239	1,621	1,464	0	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	1,471	0	0	163	0	50.03
51.00	05100	RECOVERY ROOM	673	900	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,367	0	79	414	0	52.00
53.00	05300	ANESTHESIOLOGY	1,269	2,222	79	223	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,663	8,352	1,869	484	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	10,210	3,621	8	370	0	60.00
64.00	06400	INTRAVENOUS THERAPY	944	4,192	61	229	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,755	1,648	143	261	0	65.00
66.00	06600	PHYSICAL THERAPY	4,568	4,932	0	114	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	480	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	194	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	705	558	165	125	0	69.00
69.02	06902	CARDIAC REHAB	618	3,615	0	218	0	69.02
69.03	06903	WOUND CARE	32	0	64	468	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	271	84	0	82	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	804	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,891	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,340	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	7,417	7,609	287	795	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,627	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	3,994	3,746	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	5,447	4,328	0	490	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	3,722	0	0	0	0	88.04
90.00	09000	CLINIC	7,649	9,389	0	1,497	0	90.00
91.00	09100	EMERGENCY	7,313	3,415	1,867	816	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	228	44	515	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	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	145,532	127,349	20,472	17,811	18,677	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15	341	0	0	1,029	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MOB	972	22,165	0	0	0	192.01
192.02	19202	COMMUNITY HEALTH	1,026	0	0	16	0	192.02
192.03	19203	OCCUPATIONAL MEDICINE	1,261	168	0	272	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	6	133	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 07/01/2021
To 09/30/2021Worksheet B
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Cost Center Description			ADMINISTRATIV E & 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	1,705	0	0	0	0	192.16
192.17	19217	STREATOR ORTHO CLINIC	5	0	0	0	0	192.17
194.00	07950	OTHER PHYSICIANS OFFICES	1,709	0	8	408	4,965	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)	152,231	150,156	20,480	18,507	24,671	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0234

Period:
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To 09/30/2021Worksheet B
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	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	27,478					11.00
13.00	01300	NURSING ADMINISTRATION	515	10,496				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	250	0	15,889			14.00
15.00	01500	PHARMACY	596	0	0	10,875		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,068	0	0	0	13,156	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,426	2,176	0	0	418	30.00
31.00	03100	INTENSIVE CARE UNIT	1,084	1,103	0	0	202	31.00
43.00	04300	NURSERY	678	689	0	0	132	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,011	1,028	0	0	1,472	50.00
50.01	05001	SAME DAY SURGERY	760	773	0	0	110	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	799	813	0	0	276	50.03
51.00	05100	RECOVERY ROOM	405	412	0	0	176	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	683	694	0	0	133	52.00
53.00	05300	ANESTHESIOLOGY	402	317	0	0	317	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,217	0	0	0	2,868	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,102	0	0	0	2,271	60.00
64.00	06400	INTRAVENOUS THERAPY	212	216	0	0	89	64.00
65.00	06500	RESPIRATORY THERAPY	716	0	0	0	99	65.00
66.00	06600	PHYSICAL THERAPY	1,403	199	0	0	327	66.00
67.00	06700	OCCUPATIONAL THERAPY	135	0	0	0	39	67.00
68.00	06800	SPEECH PATHOLOGY	72	0	0	0	31	68.00
69.00	06900	ELECTROCARDIOLOGY	371	0	0	0	223	69.00
69.02	06902	CARDIAC REHAB	153	0	0	0	50	69.02
69.03	06903	WOUND CARE	0	0	0	0	103	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	97	0	0	0	45	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,909	0	114	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	13,980	0	401	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,875	1,217	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,402	0	0	0	230	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	64	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	85	88.02
88.03	08803	RURAL HEALTH CLINIC IV	955	0	0	0	173	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	107	88.04
90.00	09000	CLINIC	2,627	0	0	0	414	90.00
91.00	09100	EMERGENCY	2,041	2,076	0	0	969	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	83	0	0	0	1	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	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,263	10,496	15,889	10,875	13,156	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	136	0	0	0	0	192.02
192.03	19203	OCCUPATIONAL MEDICINE	382	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
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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet B
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	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	424	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	273	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)	27,478	10,496	15,889	10,875	13,156	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part II
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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	
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	3,008				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,550	207,593	0	207,593	30.00
31.00	03100	INTENSIVE CARE UNIT	458	27,962	0	27,962	31.00
43.00	04300	NURSERY	0	3,422	0	3,422	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	64,726	0	64,726	50.00
50.01	05001	SAME DAY SURGERY	0	23,392	0	23,392	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	0	3,563	0	3,563	50.03
51.00	05100	RECOVERY ROOM	0	6,343	0	6,343	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,430	0	3,430	52.00
53.00	05300	ANESTHESIOLOGY	0	14,117	0	14,117	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	61,452	0	61,452	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	32,786	0	32,786	60.00
64.00	06400	INTRAVENOUS THERAPY	0	23,436	0	23,436	64.00
65.00	06500	RESPIRATORY THERAPY	0	11,548	0	11,548	65.00
66.00	06600	PHYSICAL THERAPY	0	32,275	0	32,275	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	676	0	676	67.00
68.00	06800	SPEECH PATHOLOGY	0	306	0	306	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,495	0	4,495	69.00
69.02	06902	CARDIAC REHAB	0	19,730	0	19,730	69.02
69.03	06903	WOUND CARE	0	667	0	667	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	942	0	942	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,827	0	2,827	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,272	0	20,272	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,432	0	18,432	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	49,706	0	49,706	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	11,413	0	11,413	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	23,584	0	23,584	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	29,610	0	29,610	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	12,883	0	12,883	88.04
90.00	09000	CLINIC	0	60,830	0	60,830	90.00
91.00	09100	EMERGENCY	0	32,990	0	32,990	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	1,062	0	1,062	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	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,008	806,470	0	806,470	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,806	0	2,806	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	MOB	0	115,458	0	115,458	192.01
192.02	19202	COMMUNITY HEALTH	0	1,220	0	1,220	192.02
192.03	19203	OCCUPATIONAL MEDICINE	0	2,830	0	2,830	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	694	0	694	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 07/01/2021
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
5/26/2022 8:33 am

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	2,195	0	2,195		192.16
192.17	19217	STREATOR ORTHO CLINIC	0	5	0	5		192.17
194.00	07950	OTHER PHYSICIANS OFFICES	0	7,409	0	7,409		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)	3,008	939,087	0	939,087		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
5/26/2022 8:33 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			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		218,546				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	864	864	5,627,809			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	35,078	35,078	321,415	-2,955,716	14,453,280	5.00
7.00	00700	OPERATION OF PLANT	32,385	32,385	151,959	0	921,608	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,687	3,687	0	0	63,200	8.00
9.00	00900	HOUSEKEEPING	2,480	2,480	9,371	0	491,251	9.00
10.00	01000	DIETARY	4,138	4,138	55,468	0	184,126	10.00
11.00	01100	CAFETERIA	2,416	2,416	5,525	0	156,582	11.00
13.00	01300	NURSING ADMINISTRATION	1,365	1,365	158,481	0	233,379	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,681	2,681	33,272	0	69,759	14.00
15.00	01500	PHARMACY	1,262	1,262	165,481	0	309,029	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,686	1,686	110,799	0	271,035	16.00
17.00	01700	SOCIAL SERVICE	432	432	42,834	0	61,065	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,098	31,098	517,168	0	972,989	30.00
31.00	03100	INTENSIVE CARE UNIT	3,447	3,447	156,101	0	344,651	31.00
43.00	04300	NURSERY	0	0	89,597	0	128,873	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,221	8,221	164,478	0	1,206,434	50.00
50.01	05001	SAME DAY SURGERY	3,113	3,113	112,491	0	176,533	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	0	0	60,961	0	139,667	50.03
51.00	05100	RECOVERY ROOM	865	865	43,443	0	63,867	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	90,262	0	129,829	52.00
53.00	05300	ANESTHESIOLOGY	2,136	2,136	45,920	0	120,459	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,027	8,027	319,105	0	1,012,371	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,480	3,480	184,897	0	969,300	60.00
64.00	06400	INTRAVENOUS THERAPY	4,029	4,029	49,791	0	89,656	64.00
65.00	06500	RESPIRATORY THERAPY	1,584	1,584	91,807	0	166,606	65.00
66.00	06600	PHYSICAL THERAPY	4,740	4,740	285,029	0	433,694	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	33,612	0	45,559	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	13,594	0	18,381	68.00
69.00	06900	ELECTROCARDIOLOGY	536	536	38,442	0	66,918	69.00
69.02	06902	CARDIAC REHAB	3,474	3,474	31,633	0	58,691	69.02
69.03	06903	WOUND CARE	0	0	0	0	3,076	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	81	81	18,647	0	25,754	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	76,356	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	559,331	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	601,910	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	7,313	7,313	410,151	0	704,200	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,900	151,361	0	249,398	88.01
88.02	08802	RURAL HEALTH CLINIC III	3,600	3,600	235,539	0	379,170	88.02
88.03	08803	RURAL HEALTH CLINIC IV	4,160	4,160	282,305	0	517,179	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	3,000	204,548	0	353,408	88.04
90.00	09000	CLINIC	9,024	9,024	219,528	0	726,165	90.00
91.00	09100	EMERGENCY	3,282	3,282	405,551	0	694,312	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	42	42	13,032	0	21,630	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	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	190,726	196,626	5,323,598	-2,955,716	13,817,401	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	328	328	0	0	1,421	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	92,321	192.01
192.02	19202	COMMUNITY HEALTH	0	0	63,020	0	97,398	192.02
192.03	19203	OCCUPATIONAL MEDICINE	161	161	73,446	0	119,683	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	0	0	555	192.08

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
5/26/2022 8:33 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			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	0	3	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	99,094	0	161,846	192.16
192.17	19217	STREATOR ORTHO CLINIC	0	0	0	0	432	192.17
194.00	07950	OTHER PHYSICIANS OFFICES	0	0	68,651	0	162,220	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)	289,411	649,676	1,981,721		2,955,716	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.360999	2.972720	0.352130		0.204501	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,744		152,231	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000665		0.010533	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 07/01/2021
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
5/26/2022 8:33 am

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	144,319				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,687	70,318			8.00
9.00	00900	HOUSEKEEPING	2,480	0	3,400		9.00
10.00	01000	DIETARY	4,138	0	84	19,639	10.00
11.00	01100	CAFETERIA	2,416	0	0	10,222	35,539 11.00
13.00	01300	NURSING ADMINISTRATION	1,365	0	15	0	666 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,681	319	70	0	323 14.00
15.00	01500	PHARMACY	1,262	0	24	0	771 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,686	0	18	0	1,381 16.00
17.00	01700	SOCIAL SERVICE	432	0	3	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	31,098	33,973	999	3,959	5,726 30.00
31.00	03100	INTENSIVE CARE UNIT	3,447	5,203	88	687	1,402 31.00
43.00	04300	NURSERY	0	279	78	0	877 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,221	7,312	384	0	1,307 50.00
50.01	05001	SAME DAY SURGERY	3,113	5,565	269	0	983 50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	0 50.02
50.03	05003	ENDOSCOPY	0	0	30	0	1,034 50.03
51.00	05100	RECOVERY ROOM	865	0	0	0	524 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	272	76	0	883 52.00
53.00	05300	ANESTHESIOLOGY	2,136	271	41	0	520 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,027	6,418	89	0	2,868 54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000	LABORATORY	3,480	29	68	0	1,425 60.00
64.00	06400	INTRAVENOUS THERAPY	4,029	208	42	0	274 64.00
65.00	06500	RESPIRATORY THERAPY	1,584	491	48	0	926 65.00
66.00	06600	PHYSICAL THERAPY	4,740	0	21	0	1,814 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	174 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	93 68.00
69.00	06900	ELECTROCARDIOLOGY	536	568	23	0	480 69.00
69.02	06902	CARDIAC REHAB	3,474	0	40	0	198 69.02
69.03	06903	WOUND CARE	0	220	86	0	0 69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	81	0	15	0	125 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	7,313	986	146	0	1,813 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	3,600	0	0	0	0 88.02
88.03	08803	RURAL HEALTH CLINIC IV	4,160	0	90	0	1,235 88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0 88.04
90.00	09000	CLINIC	9,024	0	275	0	3,398 90.00
91.00	09100	EMERGENCY	3,282	6,410	150	0	2,640 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	42	1,768	0	0	107 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	0	0 116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	122,399	70,292	3,272	14,868	33,967 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	328	0	0	819	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
192.01	19201	MOB	21,303	0	0	0	0 192.01
192.02	19202	COMMUNITY HEALTH	0	0	3	0	176 192.02
192.03	19203	OCCUPATIONAL MEDICINE	161	0	50	0	494 192.03
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	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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
5/26/2022 8:33 am

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	549	192.16
192.17	19217	STREATOR ORTHO CLINIC	0	0	0	0	0	192.17
194.00	07950	OTHER PHYSICIANS OFFICES	0	26	75	3,952	353	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)	1,110,078	104,484	610,788	268,699	347,043	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.691835	1.485878	179.643529	13.681908	9.765131	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	150,156	20,480	18,507	24,671	27,478	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.040445	0.291248	5.443235	1.256225	0.773179	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 07/01/2021
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
5/26/2022 8:33 am

Cost Center Description		NURSING ADMINISTRATIO N (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	
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	69,936				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	635,687			14.00
15.00	01500	PHARMACY	0	0	601,910		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	55,093,785	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	1,282	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,501	0	0	1,746,880	30.00
31.00	03100	INTENSIVE CARE UNIT	7,347	0	0	844,673	31.00
43.00	04300	NURSERY	4,593	0	0	552,472	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,851	0	0	6,158,119	50.00
50.01	05001	SAME DAY SURGERY	5,149	0	0	459,962	50.01
50.02	05002	LITHOTRIPSY	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	5,416	0	0	1,156,754	50.03
51.00	05100	RECOVERY ROOM	2,747	0	0	735,420	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,627	0	0	556,568	52.00
53.00	05300	ANESTHESIOLOGY	2,111	0	0	1,327,167	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,048,000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	9,501,743	60.00
64.00	06400	INTRAVENOUS THERAPY	1,437	0	0	372,648	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	412,451	65.00
66.00	06600	PHYSICAL THERAPY	1,324	0	0	1,369,959	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	164,050	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	131,119	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	932,236	69.00
69.02	06902	CARDIAC REHAB	0	0	0	209,852	69.02
69.03	06903	WOUND CARE	0	0	0	431,287	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	186,651	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	76,356	0	478,487	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	559,331	0	1,677,993	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	601,910	5,090,033	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	962,112	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	267,886	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	357,636	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	723,121	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	447,021	88.04
90.00	09000	CLINIC	0	0	0	1,734,204	90.00
91.00	09100	EMERGENCY	13,833	0	0	4,052,805	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	4,476	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	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,936	635,687	601,910	55,093,785	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	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	0	0	0	0	192.02
192.03	19203	OCCUPATIONAL MEDICINE	0	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	0	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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
5/26/2022 8:33 am

Cost Center Description			NURSING ADMINISTRATIO N (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)	300,803	120,850	393,773	356,150	77,415	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.301118	0.190109	0.654206	0.006464	60.386115	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,496	15,889	10,875	13,156	3,008	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.150080	0.024995	0.018067	0.000239	2.346334	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
5/26/2022 8:33 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,890,493		1,890,493	0	1,890,493	30.00
31.00	03100	INTENSIVE CARE UNIT	537,111		537,111	0	537,111	31.00
43.00	04300	NURSERY	201,545		201,545	0	201,545	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,678,276		1,678,276	0	1,678,276	50.00
50.01	05001	SAME DAY SURGERY	327,890		327,890	0	327,890	50.01
50.02	05002	LITHOTRIPSY	0		0	0	0	50.02
50.03	05003	ENDOSCOPY	214,487		214,487	0	214,487	50.03
51.00	05100	RECOVERY ROOM	105,267		105,267	0	105,267	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	202,558		202,558	0	202,558	52.00
53.00	05300	ANESTHESIOLOGY	192,028		192,028	0	192,028	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,412,575		1,412,575	0	1,412,575	54.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,281,884		1,281,884	0	1,281,884	60.00
64.00	06400	INTRAVENOUS THERAPY	158,101		158,101	0	158,101	64.00
65.00	06500	RESPIRATORY THERAPY	233,923	0	233,923	0	233,923	65.00
66.00	06600	PHYSICAL THERAPY	594,881	0	594,881	0	594,881	66.00
67.00	06700	OCCUPATIONAL THERAPY	57,635	0	57,635	0	57,635	67.00
68.00	06800	SPEECH PATHOLOGY	23,896	0	23,896	0	23,896	68.00
69.00	06900	ELECTROCARDIOLOGY	100,415		100,415	0	100,415	69.00
69.02	06902	CARDIAC REHAB	107,889		107,889	0	107,889	69.02
69.03	06903	WOUND CARE	22,269		22,269	0	22,269	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	36,767		36,767	0	36,767	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	109,580		109,580	0	109,580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	790,896		790,896	0	790,896	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,151,676		1,151,676	0	1,151,676	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	956,076		956,076	0	956,076	88.00
88.01	08801	RURAL HEALTH CLINIC II	302,132		302,132	0	302,132	88.01
88.02	08802	RURAL HEALTH CLINIC III	486,714		486,714	0	486,714	88.02
88.03	08803	RURAL HEALTH CLINIC IV	687,843		687,843	0	687,843	88.03
88.04	08804	RURAL HEALTH CLINIC V	428,570		428,570	0	428,570	88.04
90.00	09000	CLINIC	1,037,871		1,037,871	0	1,037,871	90.00
91.00	09100	EMERGENCY	1,009,489		1,009,489	0	1,009,489	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	525,067		525,067	0	525,067	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	30,077		30,077	0	30,077	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	0	116.00
200.00		Subtotal (see instructions)	16,895,881	0	16,895,881	0	16,895,881	200.00
201.00		Less Observation Beds	525,067		525,067	0	525,067	201.00
202.00		Total (see instructions)	16,370,814	0	16,370,814	0	16,370,814	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
5/26/2022 8:33 am

			Title XVIII			Hospital	PPS
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,035,966		1,035,966		30.00
31.00	03100	INTENSIVE CARE UNIT	844,673		844,673		31.00
43.00	04300	NURSERY	552,472		552,472		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	956,902	5,201,217	6,158,119	0.272531	0.000000
50.01	05001	SAME DAY SURGERY	708	459,254	459,962	0.712863	0.000000
50.02	05002	LITHOTRIPSY	0	0	0	0.000000	0.000000
50.03	05003	ENDOSCOPY	44,771	1,111,983	1,156,754	0.185421	0.000000
51.00	05100	RECOVERY ROOM	145,195	590,225	735,420	0.143139	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	556,568	0	556,568	0.363941	0.000000
53.00	05300	ANESTHESIOLOGY	154,980	1,172,187	1,327,167	0.144690	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,043,017	11,004,983	12,048,000	0.117246	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000
60.00	06000	LABORATORY	1,332,234	8,169,509	9,501,743	0.134910	0.000000
64.00	06400	INTRAVENOUS THERAPY	0	372,648	372,648	0.424264	0.000000
65.00	06500	RESPIRATORY THERAPY	241,211	171,240	412,451	0.567153	0.000000
66.00	06600	PHYSICAL THERAPY	128,468	1,241,491	1,369,959	0.434233	0.000000
67.00	06700	OCCUPATIONAL THERAPY	32,908	131,142	164,050	0.351326	0.000000
68.00	06800	SPEECH PATHOLOGY	11,919	119,200	131,119	0.182247	0.000000
69.00	06900	ELECTROCARDIOLOGY	94,000	838,236	932,236	0.107714	0.000000
69.02	06902	CARDIAC REHAB	0	209,852	209,852	0.514119	0.000000
69.03	06903	WOUND CARE	0	431,287	431,287	0.051634	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	186,651	186,651	0.196983	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	373,262	105,225	478,487	0.229014	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	335,286	1,342,707	1,677,993	0.471335	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,476,969	3,613,064	5,090,033	0.226261	0.000000
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	962,112	962,112		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	267,886	267,886		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	357,636	357,636		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	723,121	723,121		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	447,021	447,021		88.04
90.00	09000	CLINIC	6,000	1,728,204	1,734,204	0.598471	0.000000
91.00	09100	EMERGENCY	647,767	3,405,038	4,052,805	0.249084	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	53,152	657,762	710,914	0.738580	0.000000
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	684	3,792	4,476	6.719616	0.000000
	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		116.00
200.00		Subtotal (see instructions)	10,069,112	45,024,673	55,093,785		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	10,069,112	45,024,673	55,093,785		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN:14-0234	Period: From 07/01/2021 To 09/30/2021	Worksheet C Part I Date/Time Prepared: 5/26/2022 8:33 am
				Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio			
			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	0.272531			50.00
50.01	05001	SAME DAY SURGERY	0.712863			50.01
50.02	05002	LITHOTRIPSY	0.000000			50.02
50.03	05003	ENDOSCOPY	0.185421			50.03
51.00	05100	RECOVERY ROOM	0.143139			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.363941			52.00
53.00	05300	ANESTHESIOLOGY	0.144690			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.117246			54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.134910			60.00
64.00	06400	INTRAVENOUS THERAPY	0.424264			64.00
65.00	06500	RESPIRATORY THERAPY	0.567153			65.00
66.00	06600	PHYSICAL THERAPY	0.434233			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.351326			67.00
68.00	06800	SPEECH PATHOLOGY	0.182247			68.00
69.00	06900	ELECTROCARDIOLOGY	0.107714			69.00
69.02	06902	CARDIAC REHAB	0.514119			69.02
69.03	06903	WOUND CARE	0.051634			69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.196983			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.229014			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.471335			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.226261			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	0.598471			90.00
91.00	09100	EMERGENCY	0.249084			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.738580			92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	6.719616			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 07/01/2021
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
5/26/2022 8:33 am

				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	1,890,493		1,890,493	0	1,890,493	30.00	
31.00	03100	INTENSIVE CARE UNIT	537,111		537,111	0	537,111	31.00	
43.00	04300	NURSERY	201,545		201,545	0	201,545	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,678,276		1,678,276	0	1,678,276	50.00	
50.01	05001	SAME DAY SURGERY	327,890		327,890	0	327,890	50.01	
50.02	05002	LITHOTRIPSY	0		0	0	0	50.02	
50.03	05003	ENDOSCOPY	214,487		214,487	0	214,487	50.03	
51.00	05100	RECOVERY ROOM	105,267		105,267	0	105,267	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	202,558		202,558	0	202,558	52.00	
53.00	05300	ANESTHESIOLOGY	192,028		192,028	0	192,028	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,412,575		1,412,575	0	1,412,575	54.00	
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00	
60.00	06000	LABORATORY	1,281,884		1,281,884	0	1,281,884	60.00	
64.00	06400	INTRAVENOUS THERAPY	158,101		158,101	0	158,101	64.00	
65.00	06500	RESPIRATORY THERAPY	233,923	0	233,923	0	233,923	65.00	
66.00	06600	PHYSICAL THERAPY	594,881	0	594,881	0	594,881	66.00	
67.00	06700	OCCUPATIONAL THERAPY	57,635	0	57,635	0	57,635	67.00	
68.00	06800	SPEECH PATHOLOGY	23,896	0	23,896	0	23,896	68.00	
69.00	06900	ELECTROCARDIOLOGY	100,415		100,415	0	100,415	69.00	
69.02	06902	CARDIAC REHAB	107,889		107,889	0	107,889	69.02	
69.03	06903	WOUND CARE	22,269		22,269	0	22,269	69.03	
70.00	07000	ELECTROENCEPHALOGRAPHY	36,767		36,767	0	36,767	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	109,580		109,580	0	109,580	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	790,896		790,896	0	790,896	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,151,676		1,151,676	0	1,151,676	73.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	956,076		956,076	0	956,076	88.00	
88.01	08801	RURAL HEALTH CLINIC II	302,132		302,132	0	302,132	88.01	
88.02	08802	RURAL HEALTH CLINIC III	486,714		486,714	0	486,714	88.02	
88.03	08803	RURAL HEALTH CLINIC IV	687,843		687,843	0	687,843	88.03	
88.04	08804	RURAL HEALTH CLINIC V	428,570		428,570	0	428,570	88.04	
90.00	09000	CLINIC	1,037,871		1,037,871	0	1,037,871	90.00	
91.00	09100	EMERGENCY	1,009,489		1,009,489	0	1,009,489	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	525,067		525,067	0	525,067	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	30,077		30,077	0	30,077	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	0	116.00	
200.00		Subtotal (see instructions)	16,895,881	0	16,895,881	0	16,895,881	200.00	
201.00		Less Observation Beds	525,067		525,067	0	525,067	201.00	
202.00		Total (see instructions)	16,370,814	0	16,370,814	0	16,370,814	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
5/26/2022 8:33 am

			Title XIX			Hospital	Cost		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				9.00
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,035,966		1,035,966			30.00	
31.00	03100	INTENSIVE CARE UNIT	844,673		844,673			31.00	
43.00	04300	NURSERY	552,472		552,472			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	956,902	5,201,217	6,158,119	0.272531	0.000000	50.00	
50.01	05001	SAME DAY SURGERY	708	459,254	459,962	0.712863	0.000000	50.01	
50.02	05002	LITHOTRIPSY	0	0	0	0.000000	0.000000	50.02	
50.03	05003	ENDOSCOPY	44,771	1,111,983	1,156,754	0.185421	0.000000	50.03	
51.00	05100	RECOVERY ROOM	145,195	590,225	735,420	0.143139	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	556,568	0	556,568	0.363941	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	154,980	1,172,187	1,327,167	0.144690	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,043,017	11,004,983	12,048,000	0.117246	0.000000	54.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00	
60.00	06000	LABORATORY	1,332,234	8,169,509	9,501,743	0.134910	0.000000	60.00	
64.00	06400	INTRAVENOUS THERAPY	0	372,648	372,648	0.424264	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	241,211	171,240	412,451	0.567153	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	128,468	1,241,491	1,369,959	0.434233	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	32,908	131,142	164,050	0.351326	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	11,919	119,200	131,119	0.182247	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	94,000	838,236	932,236	0.107714	0.000000	69.00	
69.02	06902	CARDIAC REHAB	0	209,852	209,852	0.514119	0.000000	69.02	
69.03	06903	WOUND CARE	0	431,287	431,287	0.051634	0.000000	69.03	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	186,651	186,651	0.196983	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	373,262	105,225	478,487	0.229014	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	335,286	1,342,707	1,677,993	0.471335	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,476,969	3,613,064	5,090,033	0.226261	0.000000	73.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	962,112	962,112	0.993726	0.000000	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	267,886	267,886	1.127838	0.000000	88.01	
88.02	08802	RURAL HEALTH CLINIC III	0	357,636	357,636	1.360920	0.000000	88.02	
88.03	08803	RURAL HEALTH CLINIC IV	0	723,121	723,121	0.951214	0.000000	88.03	
88.04	08804	RURAL HEALTH CLINIC V	0	447,021	447,021	0.958725	0.000000	88.04	
90.00	09000	CLINIC	6,000	1,728,204	1,734,204	0.598471	0.000000	90.00	
91.00	09100	EMERGENCY	647,767	3,405,038	4,052,805	0.249084	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	53,152	657,762	710,914	0.738580	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	684	3,792	4,476	6.719616	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	0	0			116.00	
200.00		Subtotal (see instructions)	10,069,112	45,024,673	55,093,785			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	10,069,112	45,024,673	55,093,785			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
5/26/2022 8:33 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
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 07/01/2021 To 09/30/2021	Worksheet D Part I Date/Time Prepared: 5/26/2022 8:33 am		
				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	207,593	0	207,593	1,505	137.94	30.00	
31.00	INTENSIVE CARE UNIT	27,962		27,962	195	143.39	31.00	
43.00	NURSERY	3,422		3,422	151	22.66	43.00	
200.00	Total (lines 30 through 199)	238,977		238,977	1,851		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	518	71,453					30.00
31.00	INTENSIVE CARE UNIT	73	10,467					31.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	591	81,920					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0234	Period: From 07/01/2021 To 09/30/2021	Worksheet D Part II Date/Time Prepared: 5/26/2022 8:33 am
Title XVIII				Hospital	PPS	
Cost Center Description	Capital Related Cost (from Wkst. C, 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	64,726	6,158,119	0.010511	362,159	3,807	50.00
50.01 05001 SAME DAY SURGERY	23,392	459,962	0.050856	0	0	50.01
50.02 05002 LITHOTRIPSY	0	0	0.000000	0	0	50.02
50.03 05003 ENDOSCOPY	3,563	1,156,754	0.003080	28,766	89	50.03
51.00 05100 RECOVERY ROOM	6,343	735,420	0.008625	59,352	512	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3,430	556,568	0.006163	0	0	52.00
53.00 05300 ANESTHESIOLOGY	14,117	1,327,167	0.010637	46,430	494	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	61,452	12,048,000	0.005101	894,398	4,562	54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00 06000 LABORATORY	32,786	9,501,743	0.003451	1,036,026	3,575	60.00
64.00 06400 INTRAVENOUS THERAPY	23,436	372,648	0.062890	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	11,548	412,451	0.027998	116,221	3,254	65.00
66.00 06600 PHYSICAL THERAPY	32,275	1,369,959	0.023559	74,610	1,758	66.00
67.00 06700 OCCUPATIONAL THERAPY	676	164,050	0.004121	17,100	70	67.00
68.00 06800 SPEECH PATHOLOGY	306	131,119	0.002334	9,320	22	68.00
69.00 06900 ELECTROCARDIOLOGY	4,495	932,236	0.004822	93,999	453	69.00
69.02 06902 CARDIAC REHAB	19,730	209,852	0.094019	0	0	69.02
69.03 06903 WOUND CARE	667	431,287	0.001547	0	0	69.03
70.00 07000 ELECTROENCEPHALOGRAPHY	942	186,651	0.005047	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,827	478,487	0.005908	186,885	1,104	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	20,272	1,677,993	0.012081	128,950	1,558	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	18,432	5,090,033	0.003621	756,498	2,739	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	49,706	962,112	0.051663	0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	11,413	267,886	0.042604	0	0	88.01
88.02 08802 RURAL HEALTH CLINIC III	23,584	357,636	0.065944	0	0	88.02
88.03 08803 RURAL HEALTH CLINIC IV	29,610	723,121	0.040948	0	0	88.03
88.04 08804 RURAL HEALTH CLINIC V	12,883	447,021	0.028820	0	0	88.04
90.00 09000 CLINIC	60,830	1,734,204	0.035077	5,150	181	90.00
91.00 09100 EMERGENCY	32,990	4,052,805	0.008140	333,449	2,714	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	57,657	710,914	0.081103	53,152	4,311	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	624,088	52,656,198		4,202,465	31,203	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0234		Period: From 07/01/2021 To 09/30/2021		Worksheet D Part III Date/Time Prepared: 5/26/2022 8:33 am	
					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	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00		
43.00	04300	NURSERY	0	0	0	0	0	43.00		
200.00	Total (lines 30 through 199)		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	1,505	0.00	518	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	195	0.00	73	31.00		
43.00	04300	NURSERY		0	151	0.00	0	43.00		
200.00	Total (lines 30 through 199)			0	1,851		591	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 07/01/2021 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 5/26/2022 8:33 am	
			Title XVIII		Hospital		PPS	
Cost Center Description			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						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 07/01/2021 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 5/26/2022 8:33 am	
					Title XVIII		Hospital		PPS	
Cost Center Description					All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
					4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM		0	0	0	6,158,119	0.000000	50.00	
50.01	05001	SAME DAY SURGERY		0	0	0	459,962	0.000000	50.01	
50.02	05002	LITHOTRIPSY		0	0	0	0	0.000000	50.02	
50.03	05003	ENDOSCOPY		0	0	0	1,156,754	0.000000	50.03	
51.00	05100	RECOVERY ROOM		0	0	0	735,420	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	556,568	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY		0	0	0	1,327,167	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	12,048,000	0.000000	54.00	
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0.000000	59.00	
60.00	06000	LABORATORY		0	0	0	9,501,743	0.000000	60.00	
64.00	06400	INTRAVENOUS THERAPY		0	0	0	372,648	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY		0	0	0	412,451	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY		0	0	0	1,369,959	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	164,050	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY		0	0	0	131,119	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY		0	0	0	932,236	0.000000	69.00	
69.02	06902	CARDIAC REHAB		0	0	0	209,852	0.000000	69.02	
69.03	06903	WOUND CARE		0	0	0	431,287	0.000000	69.03	
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	186,651	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	478,487	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	1,677,993	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	5,090,033	0.000000	73.00	
OUTPATIENT SERVICE COST CENTERS										
88.00	08800	RURAL HEALTH CLINIC		0	0	0	962,112	0.000000	88.00	
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	267,886	0.000000	88.01	
88.02	08802	RURAL HEALTH CLINIC III		0	0	0	357,636	0.000000	88.02	
88.03	08803	RURAL HEALTH CLINIC IV		0	0	0	723,121	0.000000	88.03	
88.04	08804	RURAL HEALTH CLINIC V		0	0	0	447,021	0.000000	88.04	
90.00	09000	CLINIC		0	0	0	1,734,204	0.000000	90.00	
91.00	09100	EMERGENCY		0	0	0	4,052,805	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	710,914	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	52,656,198		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet D
Part IV
Date/Time Prepared:
5/26/2022 8:33 am

				Title XVIII		Hospital	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	362,159	0	2,048,358	0	50.00
50.01	05001	SAME DAY SURGERY	0.000000	0	0	184,258	0	50.01
50.02	05002	LITHOTRIPSY	0.000000	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	0.000000	28,766	0	352,959	0	50.03
51.00	05100	RECOVERY ROOM	0.000000	59,352	0	189,150	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	46,430	0	500,003	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	894,398	0	3,661,323	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,036,026	0	1,229,474	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	145,779	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	116,221	0	45,018	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	74,610	0	26,847	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	17,100	0	4,212	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	9,320	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	93,999	0	235,717	0	69.00
69.02	06902	CARDIAC REHAB	0.000000	0	0	120,818	0	69.02
69.03	06903	WOUND CARE	0.000000	0	0	215,773	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	74,070	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	186,885	0	28,005	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	128,950	0	571,388	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	756,498	0	1,629,786	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	5,150	0	180,903	0	90.00
91.00	09100	EMERGENCY	0.000000	333,449	0	718,710	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	53,152	0	254,340	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		4,202,465	0	12,416,891	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0234		Period: From 07/01/2021 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 5/26/2022 8:33 am	
				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 07/01/2021 To 09/30/2021		Worksheet D Part V Date/Time Prepared: 5/26/2022 8:33 am	
			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.272531	2,048,358	0	0	558,241	50.00
50.01	05001	SAME DAY SURGERY	0.712863	184,258	0	0	131,351	50.01
50.02	05002	LITHOTRIPSY	0.000000	0	0	0	0	50.02
50.03	05003	ENDOSCOPY	0.185421	352,959	0	0	65,446	50.03
51.00	05100	RECOVERY ROOM	0.143139	189,150	0	0	27,075	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.363941	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.144690	500,003	0	0	72,345	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.117246	3,661,323	0	0	429,275	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.134910	1,229,474	0	0	165,868	60.00
64.00	06400	INTRAVENOUS THERAPY	0.424264	145,779	0	0	61,849	64.00
65.00	06500	RESPIRATORY THERAPY	0.567153	45,018	0	0	25,532	65.00
66.00	06600	PHYSICAL THERAPY	0.434233	26,847	0	0	11,658	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.351326	4,212	0	0	1,480	67.00
68.00	06800	SPEECH PATHOLOGY	0.182247	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.107714	235,717	0	0	25,390	69.00
69.02	06902	CARDIAC REHAB	0.514119	120,818	0	0	62,115	69.02
69.03	06903	WOUND CARE	0.051634	215,773	0	0	11,141	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.196983	74,070	0	0	14,591	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.229014	28,005	0	0	6,414	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.471335	571,388	0	0	269,315	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.226261	1,629,786	0	0	368,757	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	0.598471	180,903	0	0	108,265	90.00
91.00	09100	EMERGENCY	0.249084	718,710	0	0	179,019	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.738580	254,340	0	0	187,850	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	6.719616		0	0		95.00
200.00		Subtotal (see instructions)		12,416,891	0	0	2,782,977	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		12,416,891	0	0	2,782,977	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
5/26/2022 8:33 am

			Title XVIII		Hospital	PPS
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
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				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	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	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0234	Period: From 07/01/2021 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 5/26/2022 8:33 am	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,505	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,505	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,087	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			518	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			243.34	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			250.38	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)			1,890,493	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,890,493	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)			1,890,493	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)			1,256.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			650,681	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)			650,681	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
5/26/2022 8:33 am

Cost Center Description		Title XVIII			Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	537,111	195	2,754.42	73	201,073	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					880,168	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,731,922	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					81,920	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					31,203	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					113,123	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,618,799	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					418	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,256.14	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					525,067	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-0234		Period: From 07/01/2021 To 09/30/2021		Worksheet D-1 Date/Time Prepared: 5/26/2022 8:33 am	
				Title XVIII		Hospital		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)			
		1.00	2.00	3.00	4.00	5.00			
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost	207,593	1,890,493	0.109809	525,067	57,657		90.00	
91.00	Nursing Program cost	0	1,890,493	0.000000	525,067	0		91.00	
92.00	Allied health cost	0	1,890,493	0.000000	525,067	0		92.00	
93.00	All other Medical Education	0	1,890,493	0.000000	525,067	0		93.00	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0234	Period: From 07/01/2021 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 5/26/2022 8:33 am	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		598,372		30.00
31.00	03100	INTENSIVE CARE UNIT		353,868		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.272531	362,159	98,700	50.00
50.01	05001	SAME DAY SURGERY	0.712863	0	0	50.01
50.02	05002	LITHOTRIPSY	0.000000	0	0	50.02
50.03	05003	ENDOSCOPY	0.185421	28,766	5,334	50.03
51.00	05100	RECOVERY ROOM	0.143139	59,352	8,496	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.363941	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.144690	46,430	6,718	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.117246	894,398	104,865	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.134910	1,036,026	139,770	60.00
64.00	06400	INTRAVENOUS THERAPY	0.424264	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.567153	116,221	65,915	65.00
66.00	06600	PHYSICAL THERAPY	0.434233	74,610	32,398	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.351326	17,100	6,008	67.00
68.00	06800	SPEECH PATHOLOGY	0.182247	9,320	1,699	68.00
69.00	06900	ELECTROCARDIOLOGY	0.107714	93,999	10,125	69.00
69.02	06902	CARDIAC REHAB	0.514119	0	0	69.02
69.03	06903	WOUND CARE	0.051634	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.196983	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.229014	186,885	42,799	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.471335	128,950	60,779	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.226261	756,498	171,166	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	0.598471	5,150	3,082	90.00
91.00	09100	EMERGENCY	0.249084	333,449	83,057	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.738580	53,152	39,257	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)		4,202,465	880,168	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		4,202,465	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN:14-0234	Period: From 07/01/2021 To 09/30/2021	Worksheet D-3
			Component CCN:14-U234		Date/Time Prepared: 5/26/2022 8:33 am
			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	0.272531	0	0 50.00
50.01	05001	SAME DAY SURGERY	0.712863	0	0 50.01
50.02	05002	LITHOTRIPSY	0.000000	0	0 50.02
50.03	05003	ENDOSCOPY	0.185421	0	0 50.03
51.00	05100	RECOVERY ROOM	0.143139	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.363941	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.144690	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.117246	0	0 54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.134910	0	0 60.00
64.00	06400	INTRAVENOUS THERAPY	0.424264	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.567153	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.434233	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.351326	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.182247	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.107714	0	0 69.00
69.02	06902	CARDIAC REHAB	0.514119	0	0 69.02
69.03	06903	WOUND CARE	0.051634	0	0 69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.196983	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.229014	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.471335	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.226261	0	0 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	0.598471	0	0 90.00
91.00	09100	EMERGENCY	0.249084	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.738580	0	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)		0	0 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0234	Period: From 07/01/2021 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 5/26/2022 8:33 am	
		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)			1,282,096	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			0	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			0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			40.46	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)			1.29	30.00
31.00	Percentage of Medicaid patient days (see instructions)			22.18	31.00
32.00	Sum of lines 30 and 31			23.47	32.00
33.00	Allowable disproportionate share percentage (see instructions)			8.58	33.00
34.00	Disproportionate share adjustment (see instructions)			27,501	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0234	Period: From 07/01/2021 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 5/26/2022 8:33 am	
		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)		8,290,014,521	0	35.00
35.01	Factor 3 (see instructions)		0.000042955	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		356,097	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		89,756	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		89,756		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		1,399,353		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		1,892,688		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			1,769,354	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			97,020	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			20,209	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)			1,886,583	59.00
60.00	Primary payer payments			16	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			1,886,567	61.00
62.00	Deductibles billed to program beneficiaries			188,468	62.00
63.00	Coinsurance billed to program beneficiaries			0	63.00
64.00	Allowable bad debts (see instructions)			295	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			192	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			1,698,291	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			1,620	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			-148	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			5,702	70.93
70.94	HRR adjustment amount (see instructions)			-521	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0234	Period: From 07/01/2021 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 5/26/2022 8:33 am	
		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)		18,932	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		1,686,012	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		1,701,188	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)		-15,176	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)		370,001	100.00	
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		1.0043784592	101.00	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		1,620	102.00	
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.9996	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-148	104.00	
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00	
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00	
202.00	Medicare discharges (see instructions)			202.00	
203.00	Case-mix adjustment factor (see instructions)			203.00	
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount			204.00	
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00	
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00	
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00	
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00	
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00	
210.00	Reserved for future use			210.00	
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00	
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00	
213.00	Low-volume adjustment (see instructions)			213.00	
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00	

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet DSH

Date/Time Prepared:
5/26/2022 8:33 am

		Title XVIII		Hospital		PPS	
		Original .mcx Values	Adjusted .mcx Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	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)	1.29	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	22.18	0.00			22.18	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	23.47	0.00			22.18	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)	40.46	0.00			40.46	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	8.58	0.00			7.51	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)	148	0			148	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)	161	0			161	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	17	0			17	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	326	0			326	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	1,433	0			1,433	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	37	0			37	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)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	1,470	0			1,470	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	22.18	0.00			22.18	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE				Provider CCN: 14-0234		Period: From 07/01/2021 To 09/30/2021		Worksheet DSH Date/Time Prepared: 5/26/2022 8:33 am	
				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	8.58		0.00	True	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	False	29.00		
30.00	Line 28 or 29 as applicable		8.58		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.		8.58		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 07/01/2021 To 09/30/2021	Worksheet DSH Date/Time Prepared: 5/26/2022 8:33 am
		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	7.51	28.00	
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00	
30.00	Line 28 or 29 as applicable	7.51	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.	7.51	31.00	

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/26/2022 8:33 am

		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	1,282,096	0	1,282,096		1,282,096
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0		0	0
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	0	0	0	0	0
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	0.0858	0.0858	0.0858	0.0858	
11.00	Disproportionate share adjustment (see instructions)	34.00	27,501	0	27,501	0	27,501
11.01	Uncompensated care payments	36.00	89,756	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	1,399,353	0	1,133,012	266,341	1,399,353
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	1,892,688	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	1,769,354	0	1,503,013	266,341	1,769,354

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/26/2022 8:33 am

		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
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	97,020	0	97,020	0	97,020
17.00	Special add-on payments for new technologies	54.00	20,209	0	20,209	0	20,209
17.01	Net organ aquisition cost						
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	1,620,242	266,341	1,886,583
		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	97,020	0	97,020	0	97,020
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	0	0	0	0	0
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	0.00000	0.00000	0.00000	0.00000	
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	0.00000	0.00000	0.00000	0.00000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	97,020	0	97,020	0	97,020
		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.		N				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/26/2022 8:33 am

		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	1,282,096	1,282,096		1,282,096	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0858	0.0858	0.0858		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	27,501	27,501	0	27,501	11.00
11.01	Uncompensated care payments	36.00	89,756	89,756	0	89,756	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	1,399,353	1,399,353	0	1,399,353	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	1,892,688	1,892,688	0	1,892,688	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	1,769,354	1,769,354	0	1,769,354	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	97,020	97,020	0	97,020	16.00
17.00	Special add-on payments for new technologies	54.00	20,209	20,209	0	20,209	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			1,886,583	0	1,886,583	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5			Provider CCN: 14-0234		Period: From 07/01/2021 To 09/30/2021		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/26/2022 8:33 am	
			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	97,020	97,020	0	97,020	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	0	0	0	0	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	97,020	97,020	0	97,020	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	5,702	5,702	0	5,702	30.00	
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	1,620	1,620	0	1,620	30.01	
31.00	HRR adjustment (see instructions)	70.94	-521	-521	0	-521	31.00	
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-148	-148	0	-148	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		18,932	0	18,932	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 07/01/2021 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 5/26/2022 8:33 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		2,782,977	2.00
3.00	OPPS payments		2,224,084	3.00
4.00	Outlier payment (see instructions)		6,436	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		2,230,520	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)		433,596	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,796,924	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,796,924	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,796,924	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)		10,096	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		6,562	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		1,803,486	37.00
38.00	MSP-LCC reconciliation amount from PS&R		123	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,803,363	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		1,837,600	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)		-34,237	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 07/01/2021 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 5/26/2022 8:33 am
	Title XVIII	Hospital	PPS
			Overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021Worksheet E-1
Part I
Date/Time Prepared:
5/26/2022 8:33 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,701,188		1,837,600	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)		1,701,188		1,837,600	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		15,176		34,237	6.02	
7.00	Total Medicare program liability (see instructions)		1,686,012		1,803,363	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 07/01/2021
To 09/30/2021Part I
Date/Time Prepared:
5/26/2022 8:33 am

		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		0		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)		0		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)		0		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 07/01/2021 To 09/30/2021	Worksheet E-2	
		Component CCN: 14-U234		Date/Time Prepared: 5/26/2022 8:33 am	
		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)		0	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		0	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)		0	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		0	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)		0	0	12.00
13.00	Coinurance 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)		0	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)		0	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		0	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 07/01/2021
To 09/30/2021

Worksheet G

Date/Time Prepared:
5/26/2022 8:33 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	7,902,119	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	41,973,278	0	0	0	4.00
5.00	Other receivable	794,956	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-30,919,575	0	0	0	6.00
7.00	Inventory	1,891,781	0	0	0	7.00
8.00	Prepaid expenses	1,127,836	0	0	0	8.00
9.00	Other current assets	1,103,882	0	0	0	9.00
10.00	Due from other funds	2,032,525	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	25,906,802	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	-1,228,222	0	0	0	14.00
15.00	Buildings	54,081,168	0	0	0	15.00
16.00	Accumulated depreciation	-38,831,543	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	60,901,664	0	0	0	23.00
24.00	Accumulated depreciation	-55,451,841	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	126,887	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	22,431,168	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	7,943,930	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	1,193,329	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,137,259	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	57,475,229	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	6,645,463	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,998,919	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)	83,027	0	0	0	40.00
41.00	Deferred income	6,263	0	0	0	41.00
42.00	Accelerated payments	6,607,443	0	0	0	42.00
43.00	Due to other funds	3,724,855	0	0	0	43.00
44.00	Other current liabilities	9,915,974	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	29,049,268	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	20,191,981	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)	20,191,981	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	49,241,249	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	8,233,980				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)	8,233,980	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	57,475,229	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet G-1

Date/Time Prepared:
5/26/2022 8:33 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		10,444,158		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,106,904				2.00
3.00	Total (sum of line 1 and line 2)		8,337,254		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)		8,337,254		0		11.00
12.00	CHANGE IN RESTRICTED NET ASSETS	103,274		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)		103,274		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		8,233,980		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	CHANGE IN RESTRICTED NET ASSETS		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 07/01/2021
To 09/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
5/26/2022 8:33 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,462,097		3,462,097	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)	3,462,097		3,462,097	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	927,750		927,750	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)	927,750		927,750	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,389,847		4,389,847	17.00
18.00	Ancillary services	7,511,501	45,889,632	53,401,133	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	962,112	962,112	20.00
20.01	RURAL HEALTH CLINIC II	0	267,886	267,886	20.01
20.02	RURAL HEALTH CLINIC III	0	357,636	357,636	20.02
20.03	RURAL HEALTH CLINIC IV	0	723,121	723,121	20.03
20.04	RURAL HEALTH CLINIC V	0	447,021	447,021	20.04
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	684	3,792	4,476	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	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)	11,902,032	48,651,200	60,553,232	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,140,576		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)		23,140,576		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0234

Period:
From 07/01/2021
To 09/30/2021

Worksheet G-3

Date/Time Prepared:
5/26/2022 8:33 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	60,553,232	1.00
2.00	Less contractual allowances and discounts on patients' accounts	42,338,364	2.00
3.00	Net patient revenues (line 1 minus line 2)	18,214,868	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,140,576	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,925,708	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	4,850	6.00
7.00	Income from investments	581,022	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	7,857	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	1,181	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	12,002	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	218	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	112,565	22.00
23.00	Governmental appropriations	0	23.00
24.00	NUTRITION CONSULTATION REVENUE	7,372	24.00
24.01	CBO REVENUE	71,316	24.01
24.02	TRANSPORT VEHICLE REVENUE	0	24.02
24.03	MANAGEMENT FEES	15,000	24.03
24.04	MISC REVENUE	8,281	24.04
24.05	PENSION PLAN GAIN	1,997,140	24.05
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	2,818,804	25.00
26.00	Total (line 5 plus line 25)	-2,106,904	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)	-2,106,904	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0234	Period: From 07/01/2021 To 09/30/2021	Worksheet L Parts I-III Date/Time Prepared: 5/26/2022 8:33 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		97,020	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	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)		14.34	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)		97,020	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 07/01/2021
To 09/30/2021Date/Time Prepared:
5/26/2022 8:33 am

		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	189,941	0	189,941	0	189,941
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	93,751	0	93,751	0	93,751
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	147,155	0	147,155	-25,914	121,241
10.00	Subtotal (sum of lines 1 through 9)	430,847	0	430,847	-25,914	404,933
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	24,729	24,729	0	24,729
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	109,539	109,539	0	109,539
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	134,268	134,268	0	134,268
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	430,847	134,268	565,115	-25,914	539,201
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	5,218	0	5,218	0	5,218
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	5,218	0	5,218	0	5,218
FACILITY OVERHEAD						
29.00	Facility Costs	0	17,354	17,354	0	17,354
30.00	Administrative Costs	0	98,650	98,650	0	98,650
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	116,004	116,004	0	116,004
32.00	Total facility costs (sum of lines 22, 28 and 31)	436,065	250,272	686,337	-25,914	660,423

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0234

Period:

Worksheet M-1

Component CCN: 14-8564

From 07/01/2021
To 09/30/2021Date/Time Prepared:
5/26/2022 8:33 am

		RHC I	
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)
		6.00	7.00
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	-77,670	112,271
2.00	Physician Assistant	-39,672	-39,672
3.00	Nurse Practitioner	0	93,751
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	0
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	121,241
10.00	Subtotal (sum of lines 1 through 9)	-117,342	287,591
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0
15.00	Medical Supplies	0	24,729
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	109,539
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	134,268
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-117,342	421,859
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
25.01	Telehealth	0	5,218
25.02	Chronic Care Management	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	5,218
FACILITY OVERHEAD			
29.00	Facility Costs	0	17,354
30.00	Administrative Costs	-15,000	83,650
31.00	Total Facility Overhead (sum of lines 29 and 30)	-15,000	101,004
32.00	Total facility costs (sum of lines 22, 28 and 31)	-132,342	528,081

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0234

Period:

Worksheet M-1

Component CCN: 14-8565

From 07/01/2021
To 09/30/2021Date/Time Prepared:
5/26/2022 8:33 am

		RHC II					
		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	54,612	0	54,612	0	54,612	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	29,532	0	29,532	0	29,532	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	75,079	0	75,079	-9,563	65,516	9.00
10.00	Subtotal (sum of lines 1 through 9)	159,223	0	159,223	-9,563	149,660	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	2,468	2,468	0	2,468	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	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	2,468	2,468	0	2,468	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	159,223	2,468	161,691	-9,563	152,128	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	1,701	0	1,701	0	1,701	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)	1,701	0	1,701	0	1,701	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	18,813	18,813	0	18,813	29.00
30.00	Administrative Costs	0	22,537	22,537	0	22,537	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	41,350	41,350	0	41,350	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	160,924	43,818	204,742	-9,563	195,179	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0234

Period:

Worksheet M-1

Component CCN: 14-8565

From 07/01/2021
To 09/30/2021Date/Time Prepared:
5/26/2022 8:33 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	54,612		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	29,532		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	65,516		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	149,660		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	2,468		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	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	2,468		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	152,128		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	1,701		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	1,701		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	-7,701	11,112		29.00
30.00	Administrative Costs	0	22,537		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-7,701	33,649		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-7,701	187,478		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0234

Period:

Worksheet M-1

Component CCN: 14-8562

From 07/01/2021
To 09/30/2021Date/Time Prepared:
5/26/2022 8:33 am

		RHC III					
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	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	140,548	0	140,548	0	140,548	1.00
2.00	Physician Assistant	27,507	0	27,507	-13,104	14,403	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	90,432	0	90,432	-15,710	74,722	9.00
10.00	Subtotal (sum of lines 1 through 9)	258,487	0	258,487	-28,814	229,673	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	0	0	0	0	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	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	258,487	0	258,487	-28,814	229,673	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	5,866	0	5,866	0	5,866	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)	5,866	0	5,866	0	5,866	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	8,744	8,744	0	8,744	29.00
30.00	Administrative Costs	0	40,635	40,635	0	40,635	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	49,379	49,379	0	49,379	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	264,353	49,379	313,732	-28,814	284,918	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0234

Period:

Worksheet M-1

Component CCN: 14-8562

From 07/01/2021

To 09/30/2021

Date/Time Prepared:
5/26/2022 8:33 am

				RHC III	
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	140,548	1.00	
2.00	Physician Assistant	0	14,403	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	74,722	9.00	
10.00	Subtotal (sum of lines 1 through 9)	0	229,673	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	0	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	0	19.00	
20.00	Allowable GME Costs			20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	0	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	229,673	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	5,866	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	5,866	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	0	8,744	29.00	
30.00	Administrative Costs	-4,290	36,345	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	-4,290	45,089	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	-4,290	280,628	32.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0234

Period:

Worksheet M-1

Component CCN: 14-8563

From 07/01/2021
To 09/30/2021Date/Time Prepared:
5/26/2022 8:33 am

		RHC IV				
		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	190,750	0	190,750	0	190,750
2.00	Physician Assistant	30,123	0	30,123	0	30,123
3.00	Nurse Practitioner	0	0	0	0	0
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	77,848	0	77,848	-17,836	60,012
10.00	Subtotal (sum of lines 1 through 9)	298,721	0	298,721	-17,836	280,885
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	65,950	65,950	0	65,950
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	65,950	65,950	0	65,950
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	298,721	65,950	364,671	-17,836	346,835
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	1,420	0	1,420	0	1,420
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	1,420	0	1,420	0	1,420
FACILITY OVERHEAD						
29.00	Facility Costs	0	11,116	11,116	0	11,116
30.00	Administrative Costs	0	49,371	49,371	0	49,371
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	60,487	60,487	0	60,487
32.00	Total facility costs (sum of lines 22, 28 and 31)	300,141	126,437	426,578	-17,836	408,742

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0234

Period:

Worksheet M-1

Component CCN: 14-8563

From 07/01/2021
To 09/30/2021Date/Time Prepared:
5/26/2022 8:33 am

				RHC IV	
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	190,750	1.00	
2.00	Physician Assistant	0	30,123	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	60,012	9.00	
10.00	Subtotal (sum of lines 1 through 9)	0	280,885	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	65,950	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	0	19.00	
20.00	Allowable GME Costs			20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	65,950	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	346,835	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	1,420	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	1,420	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	-9,000	2,116	29.00	
30.00	Administrative Costs	0	49,371	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	-9,000	51,487	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	-9,000	399,742	32.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0234

Period:

Worksheet M-1

Component CCN: 14-8561

From 07/01/2021

Date/Time Prepared:

To 09/30/2021

5/26/2022 8:33 am

		RHC V				
		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	81,952	0	81,952	0	81,952
2.00	Physician Assistant	54,902	0	54,902	0	54,902
3.00	Nurse Practitioner	0	0	0	0	0
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	75,392	0	75,392	-12,924	62,468
10.00	Subtotal (sum of lines 1 through 9)	212,246	0	212,246	-12,924	199,322
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	21,741	21,741	0	21,741
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	21,741	21,741	0	21,741
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	212,246	21,741	233,987	-12,924	221,063
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	5,226	0	5,226	0	5,226
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	5,226	0	5,226	0	5,226
FACILITY OVERHEAD						
29.00	Facility Costs	0	24,561	24,561	0	24,561
30.00	Administrative Costs	0	34,113	34,113	0	34,113
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	58,674	58,674	0	58,674
32.00	Total facility costs (sum of lines 22, 28 and 31)	217,472	80,415	297,887	-12,924	284,963

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0234

Period:

Worksheet M-1

Component CCN: 14-8561

From 07/01/2021
To 09/30/2021Date/Time Prepared:
5/26/2022 8:33 am

		RHC V		
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	81,952	1.00
2.00	Physician Assistant	0	54,902	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	62,468	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	199,322	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	21,741	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	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	21,741	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	221,063	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	5,226	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	5,226	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	-12,500	12,061	29.00
30.00	Administrative Costs	0	34,113	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-12,500	46,174	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-12,500	272,463	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN:14-0234

Period:

Worksheet M-2

Component CCN:14-8564

From 07/01/2021
To 09/30/2021Date/Time Prepared:
5/26/2022 8:33 am

		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	0.49	1,102	1	0	1.00
2.00	Physician Assistant	0.00	0	1	0	2.00
3.00	Nurse Practitioner	0.23	962	1	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.72	2,064		0	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)	0.72	2,064			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)				421,859	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				5,218	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				427,077	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.987782	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				101,004	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				427,995	15.00
16.00	Total overhead (sum of lines 14 and 15)				528,999	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				528,999	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				522,536	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				944,395	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN:14-0234

Period:

Worksheet M-2

Component CCN:14-8565

From 07/01/2021
To 09/30/2021Date/Time Prepared:
5/26/2022 8:33 am

		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	0.22	698	1	0		1.00
2.00	Physician Assistant	0.24	528	1	0		2.00
3.00	Nurse Practitioner	0.00	0	1	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.46	1,226		0	1,226	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)	0.46	1,226			1,226	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)					152,128	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,701	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					153,829	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.988942	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					33,649	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					114,654	15.00
16.00	Total overhead (sum of lines 14 and 15)					148,303	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					148,303	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					146,663	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					298,791	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN:14-0234

Period:

Worksheet M-2

Component CCN:14-8562

From 07/01/2021
To 09/30/2021Date/Time Prepared:
5/26/2022 8:33 am

		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	0.24	999	4,200	1,008		1.00
2.00	Physician Assistant	0.10	256	2,100	210		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.34	1,255		1,218	1,255	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)	0.34	1,255			1,255	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)					229,673	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					5,866	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					235,539	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.975095	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					45,089	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					206,086	15.00
16.00	Total overhead (sum of lines 14 and 15)					251,175	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					251,175	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					244,919	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					474,592	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0234 Component CCN: 14-8563		Period: From 07/01/2021 To 09/30/2021		Worksheet M-2 Date/Time Prepared: 5/26/2022 8:33 am	
		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	0.69	1,883	1	1		1.00
2.00	Physician Assistant	0.23	474	1	0		2.00
3.00	Nurse Practitioner	0.00	0	1	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.92	2,357		1	2,357	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)	0.92	2,357			2,357	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)					346,835	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,420	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					348,255	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.995923	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					51,487	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					288,101	15.00
16.00	Total overhead (sum of lines 14 and 15)					339,588	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					339,588	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					338,203	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					685,038	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN:14-0234

Period:

Worksheet M-2

Component CCN:14-8561

From 07/01/2021
To 09/30/2021Date/Time Prepared:
5/26/2022 8:33 am

		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	0.24	706	1	0	1.00
2.00	Physician Assistant	0.45	709	1	0	2.00
3.00	Nurse Practitioner	0.00	0	1	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.69	1,415	0	1,415	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)	0.69	1,415		1,415	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)				221,063	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				5,226	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				226,289	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.976906	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				46,174	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				156,107	15.00
16.00	Total overhead (sum of lines 14 and 15)				202,281	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				202,281	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				197,610	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				418,673	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0234 Component CCN: 14-8564	Period: From 07/01/2021 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 5/26/2022 8:33 am	
		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)			944,395	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)			944,395	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,064	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)			2,064	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			457.56	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (07/01/2021 through 09/30/2021)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	322.64	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	322.64	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	65	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	20,972	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		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	20,972	16.00
16.01	Total program charges (see instructions)(from contractor's records)			13,833	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			618	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			937	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.)			15,787	16.04
16.05	Total program cost (see instructions)		0	16,724	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			301	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			2,583	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			16,724	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)			16,724	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)			16,724	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			16,687	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)			37	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 07/01/2021 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 5/26/2022 8:33 am	
		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)			298,791	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)			298,791	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,226	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)			1,226	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			243.71	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (07/01/2021 through 09/30/2021)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	241.79	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	241.79	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	288	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	69,636	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		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	69,636	16.00
16.01	Total program charges (see instructions)(from contractor's records)			56,102	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			26,316	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			32,664	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.)			28,562	16.04
16.05	Total program cost (see instructions)		0	61,226	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			1,270	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			5,703	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			61,226	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)			61,226	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)			61,226	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			59,503	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)			1,723	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: 14-8562	Period: From 07/01/2021 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 5/26/2022 8:33 am	
			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)			474,592	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			12,446	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			462,146	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,255	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)			1,255	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			368.24	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (07/01/2021 through 09/30/2021)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	382.11	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	368.24	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	759	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	279,494	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		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	279,494	16.00
16.01	Total program charges (see instructions)(from contractor's records)			151,626	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			8,040	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			14,820	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.)			208,190	16.04
16.05	Total program cost (see instructions)		0	223,010	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			4,436	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			27,830	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			223,010	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			8,050	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			231,060	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)			231,060	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			227,973	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)			3,087	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: 14-8563	Period: From 07/01/2021 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 5/26/2022 8:33 am	
		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)			685,038	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			27,912	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			657,126	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,357	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)			2,357	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			278.80	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (07/01/2021 through 09/30/2021)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	254.46	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	254.46	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	461	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	117,306	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		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	117,306	16.00
16.01	Total program charges (see instructions)(from contractor's records)			83,896	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			20,703	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			28,948	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.)			68,377	16.04
16.05	Total program cost (see instructions)		0	97,325	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			2,887	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			12,061	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			97,325	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			707	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			98,032	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)			98,032	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			94,846	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)			3,186	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 07/01/2021 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 5/26/2022 8:33 am
		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)		418,673	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		11,208	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		407,465	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,415	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)		1,415	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		287.96	7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (07/01/2021 through 09/30/2021)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	191.19	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	191.19	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	305	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	58,313	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	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	58,313	16.00
16.01	Total program charges (see instructions)(from contractor's records)		73,182	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		18,216	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		14,515	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.)		32,826	16.04
16.05	Total program cost (see instructions)	0	47,341	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		2,766	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		10,440	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		47,341	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,532	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		49,873	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)		49,873	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		46,639	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)		3,234	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 07/01/2021
To 09/30/2021Date/Time Prepared:
5/26/2022 8:33 am

		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)	229,673	229,673	229,673	229,673	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000230	0.006415	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	53	1,473	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	751	3,746	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	804	5,219	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	229,673	229,673	229,673	229,673	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	244,919	244,919	244,919	244,919	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.003501	0.022724	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	857	5,566	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1,661	10,785	0	0	10.00
11.00	Total number of injections/infusions (from your records)	8	223	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	207.63	48.36	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	5	145	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)	1,038	7,012	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)		12,446			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)		8,050			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0234

Period:

Worksheet M-4

Component CCN: 14-8563

From 07/01/2021
To 09/30/2021Date/Time Prepared:
5/26/2022 8:33 am

		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)	280,885	280,885	280,885	280,885	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002035	0.000000	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	572	0	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	13,560	0	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	14,132	0	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	346,835	346,835	346,835	346,835	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	338,203	338,203	338,203	338,203	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.040746	0.000000	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	13,780	0	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	27,912	0	0	0	10.00
11.00	Total number of injections/infusions (from your records)	79	0	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	353.32	0.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	2	0	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)	707	0	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)		27,912			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)		707			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0234

Period:

Worksheet M-4

Component CCN: 14-8561

From 07/01/2021
To 09/30/2021Date/Time Prepared:
5/26/2022 8:33 am

		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)	199,322	199,322	199,322	199,322	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000745	0.001755	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	148	350	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	4,194	1,226	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4,342	1,576	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	221,063	221,063	221,063	221,063	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	197,610	197,610	197,610	197,610	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.019641	0.007129	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,881	1,409	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	8,223	2,985	0	0	10.00
11.00	Total number of injections/infusions (from your records)	31	73	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	265.26	40.89	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	6	23	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)	1,592	940	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)		11,208			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)		2,532			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 07/01/2021 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 5/26/2022 8:33 am	
		RHC I			
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		16,687	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			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)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		16,687		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		37		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		16,724		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 07/01/2021 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 5/26/2022 8:33 am	
		RHC II			
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		59,503	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			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)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		59,503		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		1,723		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		61,226		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 07/01/2021 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 5/26/2022 8:33 am	
		RHC III			
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		227,973	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			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)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		227,973		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		3,087		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		231,060		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 07/01/2021 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 5/26/2022 8:33 am	
		RHC IV			
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			94,846	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				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)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			94,846	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			3,186	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			98,032	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 07/01/2021 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 5/26/2022 8:33 am	
		RHC V			
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		46,639	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			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)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		46,639		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		3,234		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		49,873		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00 2.00		
8.00	Name of Contractor				8.00