

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1337	Period: From 05/01/2020 To 04/30/2021	Worksheet S Parts I-III Date/Time Prepared: 9/30/2021 1:25 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 9/30/2021	Time: 1:25 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PERRY MEMORIAL HOSPITAL (14-1337) for the cost reporting period beginning 05/01/2020 and ending 04/30/2021 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.

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

(Signed) SCOTT HARTMAN

Officer or Administrator of Provider(s)

VICE PRESIDENT OF SUPPORT SERVICES

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-60,059	-312,769	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	7,062	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		-37,835		0	10.00
10.01	RURAL HEALTH CLINIC II	0		18,718		0	10.01
200.00	Total	0	-52,997	-331,886	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: 14-1337		Period: From 05/01/2020 To 04/30/2021		Worksheet S-2 Part I Date/Time Prepared: 9/30/2021 1:25 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 530 PARK AVENUE EAST			PO Box:				1.00		
2.00	City: PRINCETON			State: IL		Zip Code: 61356		County: BUREAU 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		PERRY MEMORIAL HOSPITAL	141337	99914	1	07/15/2004	N	O	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		PERRY MEMORIAL SB/SNF	142337	99914		07/15/2004	N	O	N
8.00	Swing Beds - NF		PERRY MEMORIAL SB/SNF	142337	99914		07/15/2004	N		N
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		PERRY HOME CARE	147151	99914		05/01/2020	N	N	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		RHC-PRINCETON	148549	99914		11/04/2015	N	O	N
15.01	Hospital-Based Health Clinic - RHC II		RHC-PROMPT CARE	148583	99914		10/27/2017	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					05/01/2020		04/30/2021		20.00
21.00	Type of Control (see instructions)					8				21.00
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				N	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	N			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				2	N			23.00	
			In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
			1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		0	0	0	0	0	0	0	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part I
Date/Time Prepared:
9/30/2021 1:25 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
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.							
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
					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

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From 05/01/2020
To 04/30/2021Worksheet S-2
Part I
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9/30/2021 1:25 pm

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00

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

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		1.00	
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	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.		Y	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?	Y	105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y	106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N	108.00

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

		1.00	
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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
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1337	Period: From 05/01/2020 To 04/30/2021	Worksheet S-2 Part I Date/Time Prepared: 9/30/2021 1:25 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	244,786	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1337		Period: From 05/01/2020 To 04/30/2021		Worksheet S-2 Part I Date/Time Prepared: 9/30/2021 1:25 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					N		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.							146.00	
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N		N		N		N	
156.00	Subprovider - IPF	N		N		N		N	
157.00	Subprovider - IRF	N		N		N		N	
158.00	SUBPROVIDER								
159.00	SNF	N		N		N		N	
160.00	HOME HEALTH AGENCY	N		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	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								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)							N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1337		Period: From 05/01/2020 To 04/30/2021		Worksheet S-2 Part II Date/Time Prepared: 9/30/2021 1:25 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A	12/31/2021	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	09/13/2021	Y	09/13/2021
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part II
Date/Time Prepared:
9/30/2021 1:25 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		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.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL	NELSON		41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6124559706	JILL.NELSON@RSMUS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part II
Date/Time Prepared:
9/30/2021 1:25 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part I
Date/Time Prepared:
9/30/2021 1:25 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	8,030	44,035.00	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)		22	8,030	44,035.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	3	1,095	3,212.00	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						13.00
14.00 Total (see instructions)		25	9,125	47,247.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part I
Date/Time Prepared:
9/30/2021 1:25 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	814	5	1,290			1.00
2.00	HMO and other (see instructions)	224	69				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	227	0	233			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	7			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,041	5	1,530			7.00
8.00	INTENSIVE CARE UNIT	138	1	235			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)	1,179	6	1,765	0.00	217.65	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	1,007	0	1,514	0.00	2.77	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	6,595	1,541	19,945	0.00	39.33	26.00
26.01	RURAL HEALTH CLINIC II	528	3,441	4,661	0.00	7.46	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	267.21	27.00
28.00	Observation Bed Days		0	639			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			17			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part I
Date/Time Prepared:
9/30/2021 1:25 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	293	5	517	1.00
2.00 HMO and other (see instructions)			63	37		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	293	5	517	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
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

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-1337 Component CCN: 14-7151	Period: From 05/01/2020 To 04/30/2021	Worksheet S-4 Date/Time Prepared: 9/30/2021 1:25 pm
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		Home Health Agency I	
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		1.00		
0.00	County	BUREAU		0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	

	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	65.00	0.00	65.00	0.00	2.00
		Enter the number of hours in your normal work week		Number of Employees (Full Time Equivalent)			
				Staff	Contract	Total	
				0	1.00	2.00	

	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)	0.00		1.00	0.00	1.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.77	0.00	0.77	5.00
6.00	Direct Nursing Service			0.47	0.00	0.47	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.45	0.00	0.45	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.09	0.00	0.09	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.01	0.00	0.01	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00

	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	20994					20.00
20.01		37900					20.01
20.02		99914					20.02

		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	

	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	373	65	17	30	485	21.00
22.00	Skilled Nursing Visit Charges	63,480	10,920	3,280	5,000	82,680	22.00
23.00	Physical Therapy Visits	335	68	1	23	427	23.00
24.00	Physical Therapy Visit Charges	60,120	12,240	180	4,140	76,680	24.00
25.00	Occupational Therapy Visits	50	33	0	1	84	25.00
26.00	Occupational Therapy Visit Charges	7,000	4,620	0	140	11,760	26.00
27.00	Speech Pathology Visits	0	0	0	0	0	27.00
28.00	Speech Pathology Visit Charges	0	0	0	0	0	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	11	0	0	0	11	31.00
32.00	Home Health Aide Visit Charges	770	0	0	0	770	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	769	166	18	54	1,007	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	131,370	27,780	3,460	9,280	171,890	35.00
36.00	Total Number of Episodes (standard/non outlier)	65		13	3	81	36.00
37.00	Total Number of Outlier Episodes		9		1	10	37.00
38.00	Total Non-Routine Medical Supply Charges	3,667	635	335	245	4,882	38.00

Health Financial Systems		PERRY MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1337 Component CCN: 14-8549		Period: From 05/01/2020 To 04/30/2021 Worksheet S-8 Date/Time Prepared: 9/30/2021 1:25 pm	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	535 PARK AVENUE EAST		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	PRINCETON IL		61356	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
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	07:00		17:30	07:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?			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			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
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	BUREAU		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	17:30	07:00	17:30	07:00
		17:30		07:00	17:30

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1337

Period:

Worksheet S-8

Component CCN: 14-8549

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/30/2021 1:25 pm

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1)						
	CLINIC	07:00	17:30				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

 Provider CCN: 14-1337
 Component CCN: 14-8583

 Period:
 From 05/01/2020
 To 04/30/2021

Worksheet S-8

 Date/Time Prepared:
 9/30/2021 1:25 pm

				RHC II		Cost	
				1.00			
Clinic Address and Identification							
1.00	Street			2128 N MAIN ST		1.00	
			City	State	ZIP Code		
			1.00	2.00	3.00		
2.00	City, State, ZIP Code, County			PRINCETON IL 61356		2.00	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0		3.00
				Grant Award		Date	
				1.00		2.00	
Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
				1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0 10.00	
				Sunday		Monday	
				from	to	from	to
				1.00	2.00	3.00	4.00
				Tuesday		from	
				1.00		2.00	
11.00	Facility hours of operations (1)			CLINIC		11.00	
				08:30 14:00		08:30 20:00	
				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
				1.00	2.00	3.00	4.00
				Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	
				County		4.00	
2.00	City, State, ZIP Code, County			BUREAU		2.00	
				Tuesday	Wednesday	Thursday	
				to	from	to	from
				6.00	7.00	8.00	9.00
				10.00			
Facility hours of operations (1)							
11.00	CLINIC			20:00 08:30		20:00 08:30	
				20:00 08:30		20:00 08:30	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1337

Period:

Worksheet S-8

Component CCN: 14-8583

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/30/2021 1:25 pm

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	08:30	20:00	08:30	14:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet S-10

Date/Time Prepared:
9/30/2021 1:25 pm

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.401432	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		3,938,874	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?		N	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		11,003,302	6.00
7.00	Medicaid cost (line 1 times line 6)		4,417,078	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)		478,204	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		18,856	9.00
10.00	Stand-alone CHIP charges		67,375	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		27,046	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		8,190	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)		486,394	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	219,020	564,750	783,770
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	87,922	564,750	652,672
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	87,922	564,750	652,672
			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)		5,057,282	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		431,374	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		663,651	27.01
28.00	Non-Medicare bad debt expense (see instructions)		4,393,631	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,996,021	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,648,693	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,135,087	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet A

Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,223,373	1,223,373	376,672	1,600,045
1.01	00101	PERRY PLAZA B&F		3,636	3,636	152	3,788
1.02	00102	PROMPT CARE		0	0	0	0
1.03	00103	WALNUT CLINIC		2,057	2,057	2,076	4,133
1.04	00104	HENRY CLINIC		3,238	3,238	3,268	6,506
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,817,506	1,817,506	76,170	1,893,676
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	376,607	4,024,951	4,401,558	-404,766	3,996,792
5.01	00590	BUSINESS OFFICE	688,879	668,411	1,357,290	0	1,357,290
5.02	00591	A&G HOSPITAL-ONLY	345,063	1,844,481	2,189,544	-96,190	2,093,354
5.03	00592	A&G SHARED	1,051,469	1,884,696	2,936,165	-125,912	2,810,253
7.00	00700	OPERATION OF PLANT	476,811	1,113,392	1,590,203	0	1,590,203
7.01	00701	PERRY PLAZA PLANT OP	19,762	21,888	41,650	0	41,650
7.02	00702	PROMPT CARE PLANT OP	1,303	32,750	34,053	0	34,053
7.03	00703	WALNUT CLINIC PLANT OP	62	11,426	11,488	0	11,488
7.04	00704	HENRY CLINIC PLANT OP	410	16,960	17,370	0	17,370
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	96,190	96,190
9.00	00900	HOUSEKEEPING	261,954	165,686	427,640	0	427,640
9.01	00901	PERRY PLAZA HSKPING	0	2,923	2,923	0	2,923
9.02	00902	PROMPT CARE HSKPING	1,759	857	2,616	0	2,616
9.03	00903	WALNUT CLINIC HSKPING	115	52	167	0	167
9.04	00904	HENRY CLINIC HSKPING	2,760	678	3,438	0	3,438
10.00	01000	DIETARY	235,293	477,127	712,420	0	712,420
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	537,308	19,600	556,908	0	556,908
14.00	01400	CENTRAL SERVICES & SUPPLY	45,894	58,120	104,014	0	104,014
15.00	01500	PHARMACY	200,568	539,222	739,790	0	739,790
16.00	01600	MEDICAL RECORDS & LIBRARY	566,575	76,242	642,817	0	642,817
17.00	01700	SOCIAL SERVICE	333,112	11,924	345,036	0	345,036
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,166,457	322,898	1,489,355	32,912	1,522,267
31.00	03100	INTENSIVE CARE UNIT	361,299	194,741	556,040	0	556,040
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,194,686	1,788,782	2,983,468	-638,905	2,344,563
53.00	05300	ANESTHESIOLOGY	0	924,805	924,805	0	924,805
54.00	05400	RADIOLOGY-DIAGNOSTIC	654,599	309,299	963,898	0	963,898
55.00	05500	RADIOLOGY-THERAPEUTIC	208,790	138,013	346,803	0	346,803
56.00	05600	RADIOISOTOPE	0	174,671	174,671	0	174,671
57.00	05700	CT SCAN	44,333	163,124	207,457	0	207,457
58.00	05800	MRI	108,420	112,205	220,625	0	220,625
60.00	06000	LABORATORY	647,713	1,402,031	2,049,744	0	2,049,744
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	103,239	103,239	0	103,239
65.00	06500	RESPIRATORY THERAPY	372,284	51,180	423,464	0	423,464
66.00	06600	PHYSICAL THERAPY	729,737	33,425	763,162	0	763,162
69.00	06900	ELECTROCARDIOLOGY	37,106	34,921	72,027	0	72,027
70.00	07000	ELECTROENCEPHALOGRAPHY	0	271	271	0	271
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	638,905	638,905
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,467,866	1,467,866	0	1,467,866
76.00	03140	CARDIOLOGY	0	0	0	0	0
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	410,791	410,791	0	410,791
76.97	07697	CARDIAC REHABILITATION	94,478	3,130	97,608	0	97,608
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,987,965	471,202	3,459,167	173,745	3,632,912
88.01	08801	RURAL HEALTH CLINIC II	596,212	85,640	681,852	17,514	699,366
90.00	09000	CLINIC	1,677,352	60,800	1,738,152	118,064	1,856,216
90.01	04950	SLEEP LAB	57,276	6,361	63,637	0	63,637
90.02	09001	GENERAL SURGERY CL	513,654	209,447	723,101	41,652	764,753
90.03	09002	PM PAIN CLINIC	55,770	241,962	297,732	0	297,732
91.00	09100	EMERGENCY	1,063,281	2,693,134	3,756,415	-1,680	3,754,735
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	214,307	40,067	254,374	0	254,374
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		325,402	325,402	-325,402	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,931,423	25,790,603	43,722,026	-15,535	43,706,491
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0
194.00	07956	WALNUT & HENRY CLINICS	275,209	25,600	300,809	15,535	316,344
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	0

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet A

Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	0	0	0	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
200.00		TOTAL (SUM OF LINES 118 through 199)	18,206,632	25,816,203	44,022,835	0	44,022,835	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet A

Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-232,218	1,367,827	1.00
1.01	00101	PERRY PLAZA B&F	0	3,788	1.01
1.02	00102	PROMPT CARE	0	0	1.02
1.03	00103	WALNUT CLINIC	0	4,133	1.03
1.04	00104	HENRY CLINIC	0	6,506	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,129	1,892,547	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,067,008	5,063,800	4.00
5.01	00590	BUSINESS OFFICE	0	1,357,290	5.01
5.02	00591	A&G HOSPITAL-ONLY	0	2,093,354	5.02
5.03	00592	A&G SHARED	-256,048	2,554,205	5.03
7.00	00700	OPERATION OF PLANT	-8,187	1,582,016	7.00
7.01	00701	PERRY PLAZA PLANT OP	0	41,650	7.01
7.02	00702	PROMPT CARE PLANT OP	0	34,053	7.02
7.03	00703	WALNUT CLINIC PLANT OP	0	11,488	7.03
7.04	00704	HENRY CLINIC PLANT OP	0	17,370	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	-2,941	93,249	8.00
9.00	00900	HOUSEKEEPING	0	427,640	9.00
9.01	00901	PERRY PLAZA HSKPING	0	2,923	9.01
9.02	00902	PROMPT CARE HSKPING	0	2,616	9.02
9.03	00903	WALNUT CLINIC HSKPING	0	167	9.03
9.04	00904	HENRY CLINIC HSKPING	0	3,438	9.04
10.00	01000	DIETARY	-74,271	638,149	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	-20,414	536,494	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	104,014	14.00
15.00	01500	PHARMACY	0	739,790	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-756	642,061	16.00
17.00	01700	SOCIAL SERVICE	0	345,036	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-371,586	1,150,681	30.00
31.00	03100	INTENSIVE CARE UNIT	0	556,040	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-6,980	2,337,583	50.00
53.00	05300	ANESTHESIOLOGY	-893,957	30,848	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	963,898	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-18,377	328,426	55.00
56.00	05600	RADIOISOTOPE	0	174,671	56.00
57.00	05700	CT SCAN	0	207,457	57.00
58.00	05800	MRI	0	220,625	58.00
60.00	06000	LABORATORY	-37,260	2,012,484	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	103,239	63.00
65.00	06500	RESPIRATORY THERAPY	0	423,464	65.00
66.00	06600	PHYSICAL THERAPY	0	763,162	66.00
69.00	06900	ELECTROCARDIOLOGY	-34,955	37,072	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	271	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	638,905	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-42,506	1,425,360	73.00
76.00	03140	CARDIOLOGY	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	410,791	76.01
76.97	07697	CARDIAC REHABILITATION	0	97,608	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-32,400	3,600,512	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	699,366	88.01
90.00	09000	CLINIC	-1,483,362	372,854	90.00
90.01	04950	SLEEP LAB	0	63,637	90.01
90.02	09001	GENERAL SURGERY CL	-663,035	101,718	90.02
90.03	09002	PM PAIN CLINIC	-218,170	79,562	90.03
91.00	09100	EMERGENCY	-1,878,908	1,875,827	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	254,374	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,210,452	38,496,039	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
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	316,344	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	0	194.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet A

Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
194.05	07955	PERRY PLAZA LEASED	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	194.06
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,210,452	38,812,383	200.00

RECLASSIFICATIONS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-6

Date/Time Prepared:
9/30/2021 1:25 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	325,402	1.00	
	TOTALS		0	325,402		
	B - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	51,270	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	76,170	2.00	
3.00	PERRY PLAZA B&F	1.01	0	152	3.00	
5.00	WALNUT CLINIC	1.03	0	2,076	5.00	
6.00	HENRY CLINIC	1.04	0	3,268	6.00	
	TOTALS		0	132,936		
	C - EMPLOYEE PHYSICALS					
1.00	A&G SHARED	5.03	0	1,680	1.00	
	TOTALS		0	1,680		
	D - CONTRACT LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	96,190	1.00	
	TOTALS		0	96,190		
	E - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	638,905	1.00	
	TOTALS		0	638,905		
	F - PHYSICIAN BENEFITS					
1.00	ADULTS & PEDIATRICS	30.00	0	32,912	1.00	
2.00	RURAL HEALTH CLINIC	88.00	0	173,745	2.00	
3.00	CLINIC	90.00	0	118,064	3.00	
4.00	GENERAL SURGERY CL	90.02	0	41,652	4.00	
5.00	WALNUT & HENRY CLINICS	194.00	0	20,879	5.00	
6.00	RURAL HEALTH CLINIC II	88.01	0	17,514	6.00	
	TOTALS		0	404,766		
500.00	Grand Total: Increases		0	1,599,879	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet A-6
Date/Time Prepared:
9/30/2021 1:25 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - INTEREST						
	INTEREST EXPENSE	113.00	0	325,402	11		1.00
	TOTALS		0	325,402			
	B - PROPERTY INSURANCE						
1.00	A&G SHARED	5.03	0	127,592	12		1.00
2.00	WALNUT & HENRY CLINICS	194.00	0	5,344	12		2.00
3.00		0.00	0	0	12		3.00
5.00		0.00	0	0	12		5.00
6.00		0.00	0	0	12		6.00
	TOTALS		0	132,936			
	C - EMPLOYEE PHYSICALS						
1.00	EMERGENCY	91.00	0	1,680	0		1.00
	TOTALS		0	1,680			
	D - CONTRACT LAUNDRY						
1.00	A&G HOSPITAL-ONLY	5.02	0	96,190	0		1.00
	TOTALS		0	96,190			
	E - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	638,905	0		1.00
	TOTALS		0	638,905			
	F - PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	404,766	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		0	404,766			
500.00	Grand Total: Decreases		0	1,599,879			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet A-7
Part I
Date/Time Prepared:
9/30/2021 1:25 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	673,388	7,834	0	7,834	0	1.00	
2.00	Land Improvements	1,475,487	0	0	0	154,686	2.00	
3.00	Buildings and Fixtures	44,609,882	0	0	0	3,167,525	3.00	
4.00	Building Improvements	223,782	0	0	0	223,782	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	24,230,044	0	0	0	2,728,160	6.00	
7.00	HIT designated Assets	282,546	0	0	0	97,088	7.00	
8.00	Subtotal (sum of lines 1-7)	71,495,129	7,834	0	7,834	6,371,241	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	71,495,129	7,834	0	7,834	6,371,241	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	681,222	0					1.00
2.00	Land Improvements	1,320,801	0					2.00
3.00	Buildings and Fixtures	41,442,357	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	21,501,884	0					6.00
7.00	HIT designated Assets	185,458	0					7.00
8.00	Subtotal (sum of lines 1-7)	65,131,722	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	65,131,722	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet A-7
Part II
Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,223,373	0	0	0	0	1.00
1.01	PERRY PLAZA B&F	3,636	0	0	0	0	1.01
1.02	PROMPT CARE	0	0	0	0	0	1.02
1.03	WALNUT CLINIC	2,057	0	0	0	0	1.03
1.04	HENRY CLINIC	3,238	0	0	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	1,817,506	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,049,810	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,223,373				1.00
1.01	PERRY PLAZA B&F	0	3,636				1.01
1.02	PROMPT CARE	0	0				1.02
1.03	WALNUT CLINIC	0	2,057				1.03
1.04	HENRY CLINIC	0	3,238				1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,817,506				2.00
3.00	Total (sum of lines 1-2)	0	3,049,810				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet A-7
Part III
Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	43,444,380	0	43,444,380	0.667023	0	1.00
1.01	PERRY PLAZA B&F	0	0	0	0.000000	0	1.01
1.02	PROMPT CARE	0	0	0	0.000000	0	1.02
1.03	WALNUT CLINIC	0	0	0	0.000000	0	1.03
1.04	HENRY CLINIC	0	0	0	0.000000	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	21,687,342	0	21,687,342	0.332977	0	2.00
3.00	Total (sum of lines 1-2)	65,131,722	0	65,131,722	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,225,127	0	1.00
1.01	PERRY PLAZA B&F	0	0	0	3,636	0	1.01
1.02	PROMPT CARE	0	0	0	0	0	1.02
1.03	WALNUT CLINIC	0	0	0	2,057	0	1.03
1.04	HENRY CLINIC	0	0	0	3,238	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,816,377	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,050,435	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	91,430	51,270	0	0	1,367,827	1.00
1.01	PERRY PLAZA B&F	0	152	0	0	3,788	1.01
1.02	PROMPT CARE	0	0	0	0	0	1.02
1.03	WALNUT CLINIC	0	2,076	0	0	4,133	1.03
1.04	HENRY CLINIC	0	3,268	0	0	6,506	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	76,170	0	0	1,892,547	2.00
3.00	Total (sum of lines 1-2)	91,430	132,936	0	0	3,274,801	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8

Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	-73,805	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - PERRY PLAZA B&F (chapter 2)			0PERRY PLAZA B&F	1.01	0	1.01
1.02	Investment income - PROMPT CARE (chapter 2)			0PROMPT CARE	1.02	0	1.02
1.03	Investment income - WALNUT CLINIC (chapter 2)			0WALNUT CLINIC	1.03	0	1.03
1.04	Investment income - HENRY CLINIC (chapter 2)			0HENRY CLINIC	1.04	0	1.04
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,608,090			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service	B	-2,941	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-2,376	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - PERRY PLAZA B&F			0PERRY PLAZA B&F	1.01	0	26.01
26.02	Depreciation - PROMPT CARE			0PROMPT CARE	1.02	0	26.02
26.03	Depreciation - WALNUT CLINIC			0WALNUT CLINIC	1.03	0	26.03
26.04	Depreciation - HENRY CLINIC			0HENRY CLINIC	1.04	0	26.04
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8

Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-1,129	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	CAFETERIA	B	-41,010	DIETARY	10.00	0	33.00
33.01	DIETICIAN REVENUE	B	-11,496	DIETARY	10.00	0	33.01
33.02	OUTSIDE CATERING	B	96	DIETARY	10.00	0	33.02
33.03	MEDICAL RECORDS	B	-756	MEDICAL RECORDS & LIBRARY	16.00	0	33.03
33.04	CONTRACT NURSING	B	-20,414	NURSING ADMINISTRATION	13.00	0	33.04
33.05	MISCELLANEOUS	B	0	A&G SHARED	5.03	0	33.05
33.06	MOBILE MEALS	A	-17,985	DIETARY	10.00	0	33.06
33.07	GASB 68	A	1,538,161	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	TELEPHONE EXPENSE	A	-8,187	OPERATION OF PLANT	7.00	0	33.08
33.09	340B EXPENSE OFFSET	A	-42,506	DRUGS CHARGED TO PATIENTS	73.00	0	33.09
33.11	MEDICAL DIRECTOR TO A SNF	B	-32,400	RURAL HEALTH CLINIC	88.00	0	33.11
33.12	AMORTIZATION EXPENSE	A	-160,167	CAP REL COSTS-BLDG & FIXT	1.00	11	33.12
33.13	TELEPHONE SALARY OFFSET	A	0	A&G HOSPITAL-ONLY	5.02	0	33.13
33.14	TELEPHONE BENEFIT OFFSET	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	NON-ALLOWABLE MARKETING	A	-241,957	A&G SHARED	5.03	0	33.15
33.16	MARKETING BENEFITS	A	-15,297	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.16
33.17	RENTAL PROPERTY - CAPITAL	A	1,754	CAP REL COSTS-BLDG & FIXT	1.00	9	33.17
33.18	2004 BOND INTEREST	A	0	CAP REL COSTS-BLDG & FIXT	1.00	11	33.18
33.21	IHA DUES OFFSET	A	-13,841	A&G SHARED	5.03	0	33.21
33.22	ALCOHOL EXP	A	0	A&G SHARED	5.03	0	33.22
33.23	PHYSICIAN ON CALL	A	0	A&G SHARED	5.03	0	33.23
33.24	SELF-INSURANCE OFFSET	A	-436,726	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.24
33.25	UNFUNDED OTHER POST EMPLOYMENT BENEF	A	-19,130	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.25
33.26	SOCIAL ORG. DUES - PRINCETON ROTARY	B	-250	A&G SHARED	5.03	0	33.26
33.27	NON-ALLOWABLE NOTE INTEREST	A	0	CAP REL COSTS-BLDG & FIXT	1.00	11	33.27
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,210,452				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet A-8-2

Date/Time Prepared:
9/30/2021 1:25 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	2,398,530	1,878,908	519,622	0	0	1.00
2.00	90.00	CLINIC	2,398	2,398	0	0	0	2.00
3.00	90.00	CLINIC	1,480,964	1,480,964	0	0	0	3.00
4.00	90.02	GENERAL SURGERY CL	462,749	462,749	0	0	0	4.00
5.00	50.00	OPERATING ROOM	6,980	6,980	0	0	0	5.00
6.00	60.00	LABORATORY	37,260	37,260	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	893,957	893,957	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	5.03	A&G SHARED	22,500	0	22,500	0	0	9.00
10.00	30.00	ADULTS & PEDIATRICS	174,811	174,811	0	0	0	10.00
11.00	30.00	ADULTS & PEDIATRICS	196,775	196,775	0	0	0	11.00
12.00	90.03	PM PAIN CLINIC	218,170	218,170	0	0	0	12.00
13.00	69.00	ELECTROCARDIOLOGY	34,955	34,955	0	0	0	13.00
14.00	55.00	RADIOLOGY-THERAPEUTIC	18,377	18,377	0	0	0	14.00
16.00	10.00	DIETARY	1,500	1,500	0	0	0	16.00
17.00	90.02	GENERAL SURGERY CL	200,286	200,286	0	0	0	17.00
200.00			6,150,212	5,608,090	542,122			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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	90.00	CLINIC	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	90.02	GENERAL SURGERY CL	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	5.03	A&G SHARED	0	0	0	0	0	9.00
10.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	10.00
11.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	11.00
12.00	90.03	PM PAIN CLINIC	0	0	0	0	0	12.00
13.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	13.00
14.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	14.00
16.00	10.00	DIETARY	0	0	0	0	0	16.00
17.00	90.02	GENERAL SURGERY CL	0	0	0	0	0	17.00
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	91.00	EMERGENCY	0	0	0	1,878,908		1.00
2.00	90.00	CLINIC	0	0	0	2,398		2.00
3.00	90.00	CLINIC	0	0	0	1,480,964		3.00
4.00	90.02	GENERAL SURGERY CL	0	0	0	462,749		4.00
5.00	50.00	OPERATING ROOM	0	0	0	6,980		5.00
6.00	60.00	LABORATORY	0	0	0	37,260		6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	893,957		7.00
8.00	0.00		0	0	0	0		8.00
9.00	5.03	A&G SHARED	0	0	0	0		9.00
10.00	30.00	ADULTS & PEDIATRICS	0	0	0	174,811		10.00
11.00	30.00	ADULTS & PEDIATRICS	0	0	0	196,775		11.00
12.00	90.03	PM PAIN CLINIC	0	0	0	218,170		12.00
13.00	69.00	ELECTROCARDIOLOGY	0	0	0	34,955		13.00
14.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	18,377		14.00
16.00	10.00	DIETARY	0	0	0	1,500		16.00
17.00	90.02	GENERAL SURGERY CL	0	0	0	200,286		17.00
200.00			0	0	0	5,608,090		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1337		Period: From 05/01/2020 To 04/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/30/2021 1:25 pm	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					10	1.00
2.00	Line 1 multiplied by 15 hours per week					150	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	109.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	98.30	78.64	58.98	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.32	39.32	29.49			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					8,591	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					8,591	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					8,591	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					78.64	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					11,796	22.00
23.00	Total salary equivalency (see instructions)					11,796	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1337		Period: From 05/01/2020 To 04/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/30/2021 1:25 pm	
				Speech Pathology		Cost	
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	78.64	58.98	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					11,796	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					11,796	63.00
64.00	Total cost of outside supplier services (from your records)					0	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					0	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
			BLDG & FIXT	PERRY PLAZA B&F	PROMPT CARE	WALNUT CLINIC	
		0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,367,827	1,367,827			1.00
1.01	00101	PERRY PLAZA B&F	3,788	0	3,788		1.01
1.02	00102	PROMPT CARE	0	0	0		1.02
1.03	00103	WALNUT CLINIC	4,133	0	0	4,133	1.03
1.04	00104	HENRY CLINIC	6,506	0	0	0	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,892,547				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,063,800	6,579	0	0	4.00
5.01	00500	BUSINESS OFFICE	1,357,290	36,821	0	0	5.01
5.02	00501	A&G HOSPITAL-ONLY	2,093,354	57,666	23	0	5.02
5.03	00502	A&G SHARED	2,554,205	111,609	0	0	5.03
7.00	00700	OPERATION OF PLANT	1,582,016	170,173	584	0	7.00
7.01	00701	PERRY PLAZA PLANT OP	41,650	0	26	0	7.01
7.02	00702	PROMPT CARE PLANT OP	34,053	0	0	0	7.02
7.03	00703	WALNUT CLINIC PLANT OP	11,488	0	0	0	7.03
7.04	00704	HENRY CLINIC PLANT OP	17,370	0	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	93,249	20,707	0	0	8.00
9.00	00900	HOUSEKEEPING	427,640	17,487	0	0	9.00
9.01	00901	PERRY PLAZA HSKPING	2,923	0	0	0	9.01
9.02	00902	PROMPT CARE HSKPING	2,616	0	0	0	9.02
9.03	00903	WALNUT CLINIC HSKPING	167	0	0	76	9.03
9.04	00904	HENRY CLINIC HSKPING	3,438	0	0	0	9.04
10.00	01000	DIETARY	638,149	38,449	0	0	10.00
11.00	01100	CAFETERIA	0	19,115	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	536,494	14,895	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	104,014	13,442	0	0	14.00
15.00	01500	PHARMACY	739,790	17,202	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	642,061	34,112	0	0	16.00
17.00	01700	SOCIAL SERVICE	345,036	14,391	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,150,681	120,108	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	556,040	24,883	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,337,583	176,370	0	0	50.00
53.00	05300	ANESTHESIOLOGY	30,848	1,300	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	963,898	35,142	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	328,426	2,468	0	0	55.00
56.00	05600	RADIOISOTOPE	174,671	4,301	0	0	56.00
57.00	05700	CT SCAN	207,457	0	0	0	57.00
58.00	05800	MRI	220,625	9,360	0	0	58.00
60.00	06000	LABORATORY	2,012,484	29,330	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	103,239	0	0	543	63.00
65.00	06500	RESPIRATORY THERAPY	423,464	14,909	0	0	65.00
66.00	06600	PHYSICAL THERAPY	763,162	35,682	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	37,072	1,008	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	271	2,497	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	638,905	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,425,360	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	410,791	9,448	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	97,608	10,843	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,600,512	59,762	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	699,366	0	0	0	88.01
90.00	09000	CLINIC	372,854	26,037	0	0	90.00
90.01	04950	SLEEP LAB	63,637	7,973	0	0	90.01
90.02	09001	GENERAL SURGERY CL	101,718	9,346	0	0	90.02
90.03	09002	PM PAIN CLINIC	79,562	7,542	0	0	90.03
91.00	09100	EMERGENCY	1,875,827	60,616	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	254,374	3,943	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,496,039	1,225,516	633	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,834	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	PERRY PLAZA B&F	PROMPT CARE	WALNUT CLINIC	
			0	1.00	1.01	1.02	1.03	
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	316,344	0	0	0	2,961	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	17,720	0	0	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	119,757	0	0	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	3,155	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,812,383	1,367,827	3,788	0	4,133	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
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9/30/2021 1:25 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	BUSINESS OFFICE	Subtotal	
			HENRY CLINIC	MVBLE EQUIP				
			1.04	2.00				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	PERRY PLAZA B&F						1.01
1.02	00102	PROMPT CARE						1.02
1.03	00103	WALNUT CLINIC						1.03
1.04	00104	HENRY CLINIC	6,506					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,892,547				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	5,070,379			4.00
5.01	00590	BUSINESS OFFICE	0	523	236,848	1,631,482		5.01
5.02	00591	A&G HOSPITAL-ONLY	0	1,046,278	82,018	0	3,279,339	5.02
5.03	00592	A&G SHARED	0	5,917	361,513	0	3,033,244	5.03
7.00	00700	OPERATION OF PLANT	0	656	163,936	0	1,917,365	7.00
7.01	00701	PERRY PLAZA PLANT OP	0	31	6,795	0	48,502	7.01
7.02	00702	PROMPT CARE PLANT OP	0	0	448	0	34,501	7.02
7.03	00703	WALNUT CLINIC PLANT OP	0	0	21	0	12,062	7.03
7.04	00704	HENRY CLINIC PLANT OP	1,690	0	141	0	19,201	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	214	0	0	114,170	8.00
9.00	00900	HOUSEKEEPING	0	300	90,064	0	535,491	9.00
9.01	00901	PERRY PLAZA HSKPING	0	0	0	0	2,923	9.01
9.02	00902	PROMPT CARE HSKPING	0	0	605	0	3,221	9.02
9.03	00903	WALNUT CLINIC HSKPING	0	0	40	0	283	9.03
9.04	00904	HENRY CLINIC HSKPING	259	0	949	0	4,646	9.04
10.00	01000	DIETARY	0	11,729	80,898	0	769,225	10.00
11.00	01100	CAFETERIA	0	0	0	0	19,115	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	184,736	0	736,125	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,283	15,779	0	138,518	14.00
15.00	01500	PHARMACY	0	859	68,959	0	826,810	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,749	194,798	0	873,720	16.00
17.00	01700	SOCIAL SERVICE	0	0	114,530	0	473,957	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	38,265	344,709	60,834	1,714,597	30.00
31.00	03100	INTENSIVE CARE UNIT	0	29,678	124,221	13,201	748,023	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	176,058	410,753	249,178	3,349,942	50.00
53.00	05300	ANESTHESIOLOGY	0	56,082	0	18,675	106,905	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	300,335	225,062	74,319	1,598,756	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	37,238	71,786	47,528	487,446	55.00
56.00	05600	RADIOISOTOPE	0	0	0	15,652	194,624	56.00
57.00	05700	CT SCAN	0	994	15,242	197,067	420,760	57.00
58.00	05800	MRI	0	2,168	37,277	50,340	319,770	58.00
60.00	06000	LABORATORY	1,437	36,709	222,695	276,348	2,579,546	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	7,025	110,264	63.00
65.00	06500	RESPIRATORY THERAPY	0	10,443	127,998	25,003	601,817	65.00
66.00	06600	PHYSICAL THERAPY	0	6,235	250,896	67,529	1,123,504	66.00
69.00	06900	ELECTROCARDIOLOGY	0	5,013	12,758	18,615	74,466	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	419	0	225	3,412	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	28,098	667,003	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	154,319	1,579,679	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	0	10,882	431,121	76.01
76.97	07697	CARDIAC REHABILITATION	0	9,393	32,483	7,452	157,779	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	21,655	726,148	79,049	4,487,126	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	26,517	199,049	16,335	941,267	88.01
90.00	09000	CLINIC	0	11,529	102,454	11,073	523,947	90.00
90.01	04950	SLEEP LAB	0	4,577	19,692	9,245	105,124	90.01
90.02	09001	GENERAL SURGERY CL	0	0	31,823	1,764	144,651	90.02
90.03	09002	PM PAIN CLINIC	0	1,283	19,175	1,988	109,550	90.03
91.00	09100	EMERGENCY	0	40,791	365,574	186,100	2,528,908	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	73,682	3,638	335,637	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,386	1,889,921	5,016,555	1,631,482	38,288,042	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	4,834	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	3,120	2,626	53,824	0	378,875	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	BUSINESS OFFICE	Subtotal	
			HENRY CLINIC	MVBLE EQUIP				
			1.04	2.00			5A.01	
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	17,720	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	0	0	0	119,757	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	3,155	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,506	1,892,547	5,070,379	1,631,482	38,812,383	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
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Cost Center Description		A&G HOSPITAL-ONLY	Subtotal	A&G SHARED	OPERATION OF PLANT	PERRY PLAZA PLANT OP	
		5.02	5A.02	5.03	7.00	7.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	PERRY PLAZA B&F					1.01
1.02	00102	PROMPT CARE					1.02
1.03	00103	WALNUT CLINIC					1.03
1.04	00104	HENRY CLINIC					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	BUSINESS OFFICE					5.01
5.02	00591	A&G HOSPITAL-ONLY	3,279,339				5.02
5.03	00592	A&G SHARED	281,088	3,314,332	3,314,332		5.03
7.00	00700	OPERATION OF PLANT	177,680	2,095,045	195,608	2,290,653	7.00
7.01	00701	PERRY PLAZA PLANT OP	4,495	52,997	4,948	0	57,945
7.02	00702	PROMPT CARE PLANT OP	3,197	37,698	3,520	0	0
7.03	00703	WALNUT CLINIC PLANT OP	1,118	13,180	1,231	0	0
7.04	00704	HENRY CLINIC PLANT OP	1,779	20,980	1,959	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	10,580	124,750	11,648	48,155	0
9.00	00900	HOUSEKEEPING	49,623	585,114	54,630	40,667	0
9.01	00901	PERRY PLAZA HSKPING	271	3,194	298	0	0
9.02	00902	PROMPT CARE HSKPING	298	3,519	329	0	0
9.03	00903	WALNUT CLINIC HSKPING	26	309	29	0	0
9.04	00904	HENRY CLINIC HSKPING	431	5,077	474	0	0
10.00	01000	DIETARY	71,283	840,508	78,476	89,417	0
11.00	01100	CAFETERIA	1,771	20,886	1,950	44,454	0
13.00	01300	NURSING ADMINISTRATION	68,216	804,341	75,099	34,639	0
14.00	01400	CENTRAL SERVICES & SUPPLY	12,836	151,354	14,131	31,260	0
15.00	01500	PHARMACY	76,620	903,430	84,351	40,005	0
16.00	01600	MEDICAL RECORDS & LIBRARY	80,967	954,687	89,136	79,331	0
17.00	01700	SOCIAL SERVICE	43,921	517,878	48,353	33,468	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	158,890	1,873,487	174,922	279,321	0
31.00	03100	INTENSIVE CARE UNIT	69,319	817,342	76,313	57,868	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	310,436	3,660,378	341,759	410,171	0
53.00	05300	ANESTHESIOLOGY	9,907	116,812	10,906	3,022	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	148,155	1,746,911	163,104	81,725	0
55.00	05500	RADIOLOGY-THERAPEUTIC	45,171	532,617	49,729	5,739	0
56.00	05600	RADIOISOTOPE	18,036	212,660	19,855	10,001	0
57.00	05700	CT SCAN	38,991	459,751	42,926	0	0
58.00	05800	MRI	29,633	349,403	32,623	21,768	0
60.00	06000	LABORATORY	239,044	2,818,590	263,163	68,209	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	10,218	120,482	11,249	0	0
65.00	06500	RESPIRATORY THERAPY	55,770	657,587	61,397	34,673	0
66.00	06600	PHYSICAL THERAPY	104,114	1,227,618	114,619	82,981	0
69.00	06900	ELECTROCARDIOLOGY	6,901	81,367	7,597	2,343	0
70.00	07000	ELECTROENCEPHALOGRAPHY	316	3,728	348	5,807	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	61,811	728,814	68,047	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	146,387	1,726,066	161,158	0	0
76.00	03140	CARDIOLOGY	0	0	0	0	0
76.01	03950	SENIOR BEHAVIORAL WELLNESS	39,952	471,073	43,983	21,972	0
76.97	07697	CARDIAC REHABILITATION	14,621	172,400	16,096	25,215	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	415,824	4,902,950	457,758	138,981	0
88.01	08801	RURAL HEALTH CLINIC II	87,226	1,028,493	96,027	0	0
90.00	09000	CLINIC	48,554	572,501	53,453	60,551	0
90.01	04950	SLEEP LAB	9,742	114,866	10,725	18,542	0
90.02	09001	GENERAL SURGERY CL	13,405	158,056	14,757	21,734	0
90.03	09002	PM PAIN CLINIC	10,152	119,702	11,176	17,540	0
91.00	09100	EMERGENCY	234,351	2,763,259	257,997	140,968	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	31,103	366,740	34,241	9,169	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,244,229	38,252,932	3,262,098	1,959,696	0
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,834	451	11,241	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0
194.00	07956	WALNUT & HENRY CLINICS	35,110	413,985	38,653	0	0
194.01	07951	HOSPITAL LEASED SPACE	0	17,720	1,654	41,210	0
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0
194.03	07953	MOB LEASED SPACE	0	119,757	11,181	278,506	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
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Cost Center Description			A&G HOSPITAL-ONLY	Subtotal	A&G SHARED	OPERATION OF PLANT	PERRY PLAZA PLANT OP	
			5.02	5A.02	5.03	7.00	7.01	
194.05	07955	PERRY PLAZA LEASED	0	3,155	295	0	57,945	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,279,339	38,812,383	3,314,332	2,290,653	57,945	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
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Cost Center Description			PROMPT CARE PLANT OP	WALNUT CLINIC PLANT OP	HENRY CLINIC PLANT OP	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			7.02	7.03	7.04	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	PERRY PLAZA B&F						1.01
1.02	00102	PROMPT CARE						1.02
1.03	00103	WALNUT CLINIC						1.03
1.04	00104	HENRY CLINIC						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	BUSINESS OFFICE						5.01
5.02	00591	A&G HOSPITAL-ONLY						5.02
5.03	00592	A&G SHARED						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	PERRY PLAZA PLANT OP						7.01
7.02	00702	PROMPT CARE PLANT OP	41,218					7.02
7.03	00703	WALNUT CLINIC PLANT OP	0	14,411				7.03
7.04	00704	HENRY CLINIC PLANT OP	0	0	22,939			7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	184,553		8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	680,411	9.00
9.01	00901	PERRY PLAZA HSKPING	0	0	0	0	0	9.01
9.02	00902	PROMPT CARE HSKPING	1,811	0	0	0	0	9.02
9.03	00903	WALNUT CLINIC HSKPING	0	306	0	0	0	9.03
9.04	00904	HENRY CLINIC HSKPING	0	0	1,232	0	0	9.04
10.00	01000	DIETARY	0	0	0	0	11,585	10.00
11.00	01100	CAFETERIA	0	0	0	14	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	17,801	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,891	16,671	14.00
15.00	01500	PHARMACY	0	0	0	0	7,347	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	2,543	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	6,499	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	45,274	142,692	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	6,574	12,433	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	51,773	133,652	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,636	0	0	8,135	29,387	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	6,473	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	1,028	0	56.00
57.00	05700	CT SCAN	0	0	0	6,427	6,499	57.00
58.00	05800	MRI	0	0	0	4,606	5,934	58.00
60.00	06000	LABORATORY	2,603	2,184	6,845	0	23,453	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	9,607	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,925	14,976	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	0	0	10,455	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	58	3,956	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	673	111,047	88.00
88.01	08801	RURAL HEALTH CLINIC II	31,168	0	0	197	12,433	88.01
90.00	09000	CLINIC	0	0	0	653	283	90.00
90.01	04950	SLEEP LAB	0	0	0	0	7,064	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	292	0	90.02
90.03	09002	PM PAIN CLINIC	0	0	0	0	13,563	90.03
91.00	09100	EMERGENCY	0	0	0	41,460	64,142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	848	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,218	2,490	8,077	181,453	664,870	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
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	11,921	14,862	3,100	13,280	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	2,261	194.02
194.03	07953	MOB LEASED SPACE	0	0	0	0	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
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Cost Center Description			PROMPT CARE PLANT OP	WALNUT CLINIC PLANT OP	HENRY CLINIC PLANT OP	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			7.02	7.03	7.04	8.00	9.00	
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
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)	41,218	14,411	22,939	184,553	680,411	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
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Cost Center Description		PERRY PLAZA HSKPING	PROMPT CARE HSKPING	WALNUT CLINIC HSKPING	HENRY CLINIC HSKPING	DIETARY	
		9.01	9.02	9.03	9.04	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	PERRY PLAZA B&F					1.01
1.02	00102	PROMPT CARE					1.02
1.03	00103	WALNUT CLINIC					1.03
1.04	00104	HENRY CLINIC					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	BUSINESS OFFICE					5.01
5.02	00591	A&G HOSPITAL-ONLY					5.02
5.03	00592	A&G SHARED					5.03
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	PERRY PLAZA PLANT OP					7.01
7.02	00702	PROMPT CARE PLANT OP					7.02
7.03	00703	WALNUT CLINIC PLANT OP					7.03
7.04	00704	HENRY CLINIC PLANT OP					7.04
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
9.01	00901	PERRY PLAZA HSKPING	3,492				9.01
9.02	00902	PROMPT CARE HSKPING	0	5,659			9.02
9.03	00903	WALNUT CLINIC HSKPING	0	0	644		9.03
9.04	00904	HENRY CLINIC HSKPING	0	0	0	6,783	9.04
10.00	01000	DIETARY	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	809	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	374	100	2,139	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,476	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	04950	SLEEP LAB	0	0	0	0	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,659	100	2,139	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	0	544	4,644	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	0	0	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
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Cost Center Description			PERRY PLAZA HSKPING	PROMPT CARE HSKPING	WALNUT CLINIC HSKPING	HENRY CLINIC HSKPING	DIETARY	
			9.01	9.02	9.03	9.04	10.00	
194.05	07955	PERRY PLAZA LEASED	3,492	0	0	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
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)	3,492	5,659	644	6,783	1,019,986	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	PERRY PLAZA B&F						1.01
1.02	00102	PROMPT CARE						1.02
1.03	00103	WALNUT CLINIC						1.03
1.04	00104	HENRY CLINIC						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	BUSINESS OFFICE						5.01
5.02	00591	A&G HOSPITAL-ONLY						5.02
5.03	00592	A&G SHARED						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	PERRY PLAZA PLANT OP						7.01
7.02	00702	PROMPT CARE PLANT OP						7.02
7.03	00703	WALNUT CLINIC PLANT OP						7.03
7.04	00704	HENRY CLINIC PLANT OP						7.04
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	PERRY PLAZA HSKPING						9.01
9.02	00902	PROMPT CARE HSKPING						9.02
9.03	00903	WALNUT CLINIC HSKPING						9.03
9.04	00904	HENRY CLINIC HSKPING						9.04
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	752,968					11.00
13.00	01300	NURSING ADMINISTRATION	25,782	957,662				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,014	24,390	248,711			14.00
15.00	01500	PHARMACY	17,713	0	0	1,052,846		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	75,076	0	1	0	1,200,774	16.00
17.00	01700	SOCIAL SERVICE	29,249	0	12	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	61,019	278,425	11,232	0	44,776	30.00
31.00	03100	INTENSIVE CARE UNIT	17,020	86,271	2,464	0	9,716	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	100,606	276,037	75,417	0	183,402	50.00
53.00	05300	ANESTHESIOLOGY	0	0	3,621	0	13,745	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,988	0	398	0	54,701	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	16,831	0	2,138	0	34,982	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	11,520	56.00
57.00	05700	CT SCAN	3,782	0	4,267	0	145,047	57.00
58.00	05800	MRI	8,510	0	2,006	0	37,052	58.00
60.00	06000	LABORATORY	61,523	0	14,799	0	203,358	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	5,171	63.00
65.00	06500	RESPIRATORY THERAPY	20,109	0	2,113	0	18,403	65.00
66.00	06600	PHYSICAL THERAPY	67,197	0	2,357	0	49,703	66.00
69.00	06900	ELECTROCARDIOLOGY	5,988	0	0	0	13,701	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	13	0	166	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	103,575	0	20,681	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,052,846	113,583	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	45	0	8,010	76.01
76.97	07697	CARDIAC REHABILITATION	9,077	0	298	0	5,485	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	2,422	0	58,182	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	2,202	0	12,023	88.01
90.00	09000	CLINIC	40,721	0	3,395	0	8,150	90.00
90.01	04950	SLEEP LAB	1,198	0	529	0	6,804	90.01
90.02	09001	GENERAL SURGERY CL	22,693	0	244	0	1,298	90.02
90.03	09002	PM PAIN CLINIC	8,888	0	0	0	1,463	90.03
91.00	09100	EMERGENCY	56,291	292,539	14,439	0	136,975	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	16,957	0	414	0	2,677	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	725,232	957,662	248,401	1,052,846	1,200,774	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
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	27,736	0	310	0	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

 Period:
 From 05/01/2020
 To 04/30/2021

 Worksheet B
 Part I
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
194.03	07953	MOB LEASED SPACE	0	0	0	0	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
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)	752,968	957,662	248,711	1,052,846	1,200,774	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
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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
1.01	00101	PERRY PLAZA B&F					1.01
1.02	00102	PROMPT CARE					1.02
1.03	00103	WALNUT CLINIC					1.03
1.04	00104	HENRY CLINIC					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	BUSINESS OFFICE					5.01
5.02	00591	A&G HOSPITAL-ONLY					5.02
5.03	00592	A&G SHARED					5.03
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	PERRY PLAZA PLANT OP					7.01
7.02	00702	PROMPT CARE PLANT OP					7.02
7.03	00703	WALNUT CLINIC PLANT OP					7.03
7.04	00704	HENRY CLINIC PLANT OP					7.04
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
9.01	00901	PERRY PLAZA HSKPING					9.01
9.02	00902	PROMPT CARE HSKPING					9.02
9.03	00903	WALNUT CLINIC HSKPING					9.03
9.04	00904	HENRY CLINIC HSKPING					9.04
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	635,496				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	573,374	3,725,892	0	3,725,892	30.00
31.00	03100	INTENSIVE CARE UNIT	62,122	1,186,495	0	1,186,495	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	5,257,543	0	5,257,543	50.00
53.00	05300	ANESTHESIOLOGY	0	148,106	0	148,106	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,142,496	0	2,142,496	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	648,509	0	648,509	55.00
56.00	05600	RADIOISOTOPE	0	255,138	0	255,138	56.00
57.00	05700	CT SCAN	0	668,699	0	668,699	57.00
58.00	05800	MRI	0	461,902	0	461,902	58.00
60.00	06000	LABORATORY	0	3,467,932	0	3,467,932	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	136,902	0	136,902	63.00
65.00	06500	RESPIRATORY THERAPY	0	803,889	0	803,889	65.00
66.00	06600	PHYSICAL THERAPY	0	1,565,561	0	1,565,561	66.00
69.00	06900	ELECTROCARDIOLOGY	0	110,996	0	110,996	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	10,062	0	10,062	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	921,117	0	921,117	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,053,653	0	3,053,653	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	555,575	0	555,575	76.01
76.97	07697	CARDIAC REHABILITATION	0	232,585	0	232,585	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	5,680,080	0	5,680,080	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,187,019	0	1,187,019	88.01
90.00	09000	CLINIC	0	739,707	0	739,707	90.00
90.01	04950	SLEEP LAB	0	160,098	0	160,098	90.01
90.02	09001	GENERAL SURGERY CL	0	219,074	0	219,074	90.02
90.03	09002	PM PAIN CLINIC	0	172,332	0	172,332	90.03
91.00	09100	EMERGENCY	0	3,787,238	0	3,787,238	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	431,046	0	431,046	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	635,496	37,729,646	0	37,729,646	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,526	0	16,526	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	529,035	0	529,035	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
194.01	07951	HOSPITAL LEASED SPACE	0	60,584	0	60,584		194.01
194.02	07950	PERRY HOME CARE - HHA	0	2,261	0	2,261		194.02
194.03	07953	MOB LEASED SPACE	0	409,444	0	409,444		194.03
194.05	07955	PERRY PLAZA LEASED	0	64,887	0	64,887		194.05
194.06	07954	PM PROMPT CARE	0	0	0	0		194.06
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	635,496	38,812,383	0	38,812,383		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			BLDG & FIXT	PERRY PLAZA B&F	PROMPT CARE	WALNUT CLINIC	
		0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	PERRY PLAZA B&F					1.01
1.02	00102	PROMPT CARE					1.02
1.03	00103	WALNUT CLINIC					1.03
1.04	00104	HENRY CLINIC					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,579	0	0	4.00
5.01	00590	BUSINESS OFFICE	0	36,821	0	0	5.01
5.02	00591	A&G HOSPITAL-ONLY	0	57,666	23	0	5.02
5.03	00592	A&G SHARED	0	111,609	0	0	5.03
7.00	00700	OPERATION OF PLANT	0	170,173	584	0	7.00
7.01	00701	PERRY PLAZA PLANT OP	0	0	26	0	7.01
7.02	00702	PROMPT CARE PLANT OP	0	0	0	0	7.02
7.03	00703	WALNUT CLINIC PLANT OP	0	0	0	553	7.03
7.04	00704	HENRY CLINIC PLANT OP	0	0	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,707	0	0	8.00
9.00	00900	HOUSEKEEPING	0	17,487	0	0	9.00
9.01	00901	PERRY PLAZA HSKPING	0	0	0	0	9.01
9.02	00902	PROMPT CARE HSKPING	0	0	0	0	9.02
9.03	00903	WALNUT CLINIC HSKPING	0	0	0	76	9.03
9.04	00904	HENRY CLINIC HSKPING	0	0	0	0	9.04
10.00	01000	DIETARY	0	38,449	0	0	10.00
11.00	01100	CAFETERIA	0	19,115	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	14,895	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	13,442	0	0	14.00
15.00	01500	PHARMACY	0	17,202	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34,112	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	14,391	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	120,108	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	24,883	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	176,370	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	1,300	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,142	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,468	0	0	55.00
56.00	05600	RADIOISOTOPE	0	4,301	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	9,360	0	0	58.00
60.00	06000	LABORATORY	0	29,330	0	543	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	14,909	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	35,682	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,008	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,497	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	9,448	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	10,843	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	59,762	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
90.00	09000	CLINIC	0	26,037	0	0	90.00
90.01	04950	SLEEP LAB	0	7,973	0	0	90.01
90.02	09001	GENERAL SURGERY CL	0	9,346	0	0	90.02
90.03	09002	PM PAIN CLINIC	0	7,542	0	0	90.03
91.00	09100	EMERGENCY	0	60,616	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0				92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	3,943	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,225,516	633	0	1,172
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,834	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	192.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	PERRY PLAZA B&F	PROMPT CARE	WALNUT CLINIC	
			0	1.00	1.01	1.02	1.03	
194.00	07956	WALNUT & HENRY CLINICS	0	0	0	0	2,961	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	17,720	0	0	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	119,757	0	0	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	3,155	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,367,827	3,788	0	4,133	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	BUSINESS OFFICE	
			HENRY CLINIC	MVBLE EQUIP				
			1.04	2.00				
					2A	4.00	5.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	PERRY PLAZA B&F						1.01
1.02	00102	PROMPT CARE						1.02
1.03	00103	WALNUT CLINIC						1.03
1.04	00104	HENRY CLINIC						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	6,579	6,579		4.00
5.01	00590	BUSINESS OFFICE	0	523	37,344	307	37,651	5.01
5.02	00591	A&G HOSPITAL-ONLY	0	1,046,278	1,103,967	106	0	5.02
5.03	00592	A&G SHARED	0	5,917	117,526	469	0	5.03
7.00	00700	OPERATION OF PLANT	0	656	171,413	213	0	7.00
7.01	00701	PERRY PLAZA PLANT OP	0	31	57	9	0	7.01
7.02	00702	PROMPT CARE PLANT OP	0	0	0	1	0	7.02
7.03	00703	WALNUT CLINIC PLANT OP	0	0	553	0	0	7.03
7.04	00704	HENRY CLINIC PLANT OP	1,690	0	1,690	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	214	20,921	0	0	8.00
9.00	00900	HOUSEKEEPING	0	300	17,787	117	0	9.00
9.01	00901	PERRY PLAZA HSKPING	0	0	0	0	0	9.01
9.02	00902	PROMPT CARE HSKPING	0	0	0	1	0	9.02
9.03	00903	WALNUT CLINIC HSKPING	0	0	76	0	0	9.03
9.04	00904	HENRY CLINIC HSKPING	259	0	259	1	0	9.04
10.00	01000	DIETARY	0	11,729	50,178	105	0	10.00
11.00	01100	CAFETERIA	0	0	19,115	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	14,895	240	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,283	18,725	20	0	14.00
15.00	01500	PHARMACY	0	859	18,061	89	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,749	36,861	253	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	14,391	149	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	38,265	158,373	447	1,405	30.00
31.00	03100	INTENSIVE CARE UNIT	0	29,678	54,561	161	305	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	176,058	352,428	533	5,756	50.00
53.00	05300	ANESTHESIOLOGY	0	56,082	57,382	0	431	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	300,335	335,477	292	1,717	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	37,238	39,706	93	1,098	55.00
56.00	05600	RADIOISOTOPE	0	0	4,301	0	362	56.00
57.00	05700	CT SCAN	0	994	994	20	4,553	57.00
58.00	05800	MRI	0	2,168	11,528	48	1,163	58.00
60.00	06000	LABORATORY	1,437	36,709	68,019	289	6,346	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	162	63.00
65.00	06500	RESPIRATORY THERAPY	0	10,443	25,352	166	578	65.00
66.00	06600	PHYSICAL THERAPY	0	6,235	41,917	325	1,560	66.00
69.00	06900	ELECTROCARDIOLOGY	0	5,013	6,021	17	430	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	419	2,916	0	5	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	649	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,565	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	9,448	0	251	76.01
76.97	07697	CARDIAC REHABILITATION	0	9,393	20,236	42	172	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	21,655	81,417	943	1,826	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	26,517	26,517	258	377	88.01
90.00	09000	CLINIC	0	11,529	37,566	133	256	90.00
90.01	04950	SLEEP LAB	0	4,577	12,550	26	214	90.01
90.02	09001	GENERAL SURGERY CL	0	0	9,346	41	41	90.02
90.03	09002	PM PAIN CLINIC	0	1,283	8,825	25	46	90.03
91.00	09100	EMERGENCY	0	40,791	101,407	474	4,299	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	3,943	96	84	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,386	1,889,921	3,120,628	6,509	37,651	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	4,834	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	3,120	2,626	8,707	70	0	194.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	BUSINESS OFFICE	
			HENRY CLINIC	MVBLE EQUIP				
			1.04	2.00		4.00	5.01	
194.01	07951	HOSPITAL LEASED SPACE	0	0	17,720	0	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	0	119,757	0	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	3,155	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,506	1,892,547	3,274,801	6,579	37,651	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
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Cost Center Description		A&G HOSPITAL-ONLY	A&G SHARED	OPERATION OF PLANT	PERRY PLAZA PLANT OP	PROMPT CARE PLANT OP	
		5.02	5.03	7.00	7.01	7.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	PERRY PLAZA B&F					1.01
1.02	00102	PROMPT CARE					1.02
1.03	00103	WALNUT CLINIC					1.03
1.04	00104	HENRY CLINIC					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	BUSINESS OFFICE					5.01
5.02	00591	A&G HOSPITAL-ONLY	1,104,073				5.02
5.03	00592	A&G SHARED	94,634	212,629			5.03
7.00	00700	OPERATION OF PLANT	59,820	12,549	243,995		7.00
7.01	00701	PERRY PLAZA PLANT OP	1,513	317	0	1,896	7.01
7.02	00702	PROMPT CARE PLANT OP	1,076	226	0	0	7.02
7.03	00703	WALNUT CLINIC PLANT OP	376	79	0	1,303	7.03
7.04	00704	HENRY CLINIC PLANT OP	599	126	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	3,562	747	5,129	0	8.00
9.00	00900	HOUSEKEEPING	16,707	3,505	4,332	0	9.00
9.01	00901	PERRY PLAZA HSKPING	91	19	0	0	9.01
9.02	00902	PROMPT CARE HSKPING	100	21	0	0	9.02
9.03	00903	WALNUT CLINIC HSKPING	9	2	0	0	9.03
9.04	00904	HENRY CLINIC HSKPING	145	30	0	0	9.04
10.00	01000	DIETARY	23,999	5,035	9,524	0	10.00
11.00	01100	CAFETERIA	596	125	4,735	0	11.00
13.00	01300	NURSING ADMINISTRATION	22,966	4,818	3,690	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,322	907	3,330	0	14.00
15.00	01500	PHARMACY	25,796	5,412	4,261	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,259	5,719	8,450	0	16.00
17.00	01700	SOCIAL SERVICE	14,787	3,102	3,565	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	53,494	11,222	29,753	0	30.00
31.00	03100	INTENSIVE CARE UNIT	23,338	4,896	6,164	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	104,515	21,926	43,690	0	50.00
53.00	05300	ANESTHESIOLOGY	3,335	700	322	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,880	10,464	8,705	178	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	15,208	3,190	611	0	55.00
56.00	05600	RADIOISOTOPE	6,072	1,274	1,065	0	56.00
57.00	05700	CT SCAN	13,127	2,754	0	0	57.00
58.00	05800	MRI	9,977	2,093	2,319	0	58.00
60.00	06000	LABORATORY	80,479	16,883	7,265	82	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,440	722	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	18,776	3,939	3,693	0	65.00
66.00	06600	PHYSICAL THERAPY	35,052	7,353	8,839	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,323	487	250	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	106	22	619	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,810	4,366	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,284	10,339	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	13,451	2,822	2,340	0	76.01
76.97	07697	CARDIAC REHABILITATION	4,923	1,033	2,686	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	140,009	29,363	14,804	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	29,367	6,161	0	986	88.01
90.00	09000	CLINIC	16,347	3,429	6,450	0	90.00
90.01	04950	SLEEP LAB	3,280	688	1,975	0	90.01
90.02	09001	GENERAL SURGERY CL	4,513	947	2,315	0	90.02
90.03	09002	PM PAIN CLINIC	3,418	717	1,868	0	90.03
91.00	09100	EMERGENCY	78,899	16,552	15,016	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	10,472	2,197	977	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,092,252	209,278	208,742	0	1,303
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29	1,197	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	11,821	2,480	0	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	106	4,390	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	717	29,666	0	194.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

 Period:
 From 05/01/2020
 To 04/30/2021

 Worksheet B
 Part II
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Cost Center Description			A&G HOSPITAL-ONLY	A&G SHARED	OPERATION OF PLANT	PERRY PLAZA PLANT OP	PROMPT CARE PLANT OP	
			5.02	5.03	7.00	7.01	7.02	
194.05	07955	PERRY PLAZA LEASED	0	19	0	1,896	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,104,073	212,629	243,995	1,896	1,303	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		WALNUT CLINIC PLANT OP	HENRY CLINIC PLANT OP	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	PERRY PLAZA HSKPING	
		7.03	7.04	8.00	9.00	9.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	PERRY PLAZA B&F					1.01
1.02	00102	PROMPT CARE					1.02
1.03	00103	WALNUT CLINIC					1.03
1.04	00104	HENRY CLINIC					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	BUSINESS OFFICE					5.01
5.02	00591	A&G HOSPITAL-ONLY					5.02
5.03	00592	A&G SHARED					5.03
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	PERRY PLAZA PLANT OP					7.01
7.02	00702	PROMPT CARE PLANT OP					7.02
7.03	00703	WALNUT CLINIC PLANT OP	1,008				7.03
7.04	00704	HENRY CLINIC PLANT OP	0	2,415			7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	30,359		8.00
9.00	00900	HOUSEKEEPING	0	0	0	42,448	9.00
9.01	00901	PERRY PLAZA HSKPING	0	0	0	0	110 9.01
9.02	00902	PROMPT CARE HSKPING	0	0	0	0	9.02
9.03	00903	WALNUT CLINIC HSKPING	21	0	0	0	9.03
9.04	00904	HENRY CLINIC HSKPING	0	130	0	0	9.04
10.00	01000	DIETARY	0	0	0	723	0 10.00
11.00	01100	CAFETERIA	0	0	2	0	0 11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,111	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	311	1,040	0 14.00
15.00	01500	PHARMACY	0	0	0	458	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	159	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	405	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	7,448	8,901	0 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	1,081	776	0 31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	8,517	8,338	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,338	1,833	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	1,065	0	0 55.00
56.00	05600	RADIOISOTOPE	0	0	169	0	0 56.00
57.00	05700	CT SCAN	0	0	1,057	405	0 57.00
58.00	05800	MRI	0	0	758	370	0 58.00
60.00	06000	LABORATORY	153	721	0	1,463	0 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	599	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	975	934	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
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
76.00	03140	CARDIOLOGY	0	0	0	0	0 76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	0	652	0 76.01
76.97	07697	CARDIAC REHABILITATION	0	0	10	247	0 76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	111	6,928	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	32	776	0 88.01
90.00	09000	CLINIC	0	0	107	18	0 90.00
90.01	04950	SLEEP LAB	0	0	0	441	0 90.01
90.02	09001	GENERAL SURGERY CL	0	0	48	0	0 90.02
90.03	09002	PM PAIN CLINIC	0	0	0	846	0 90.03
91.00	09100	EMERGENCY	0	0	6,820	4,002	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	53	0 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	174	851	29,849	41,478	0 118.00
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
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0 192.03
194.00	07956	WALNUT & HENRY CLINICS	834	1,564	510	829	0 194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	0 194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	141	0 194.02
194.03	07953	MOB LEASED SPACE	0	0	0	0	0 194.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

 Period:
 From 05/01/2020
 To 04/30/2021

 Worksheet B
 Part II
 Date/Time Prepared:
 9/30/2021 1:25 pm

Cost Center Description			WALNUT CLINIC PLANT OP	HENRY CLINIC PLANT OP	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	PERRY PLAZA HSKPING	
			7.03	7.04	8.00	9.00	9.01	
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	110	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,008	2,415	30,359	42,448	110	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description		PROMPT CARE HSKPING	WALNUT CLINIC HSKPING	HENRY CLINIC HSKPING	DIETARY	CAFETERIA	
		9.02	9.03	9.04	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	PERRY PLAZA B&F					1.01
1.02	00102	PROMPT CARE					1.02
1.03	00103	WALNUT CLINIC					1.03
1.04	00104	HENRY CLINIC					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	BUSINESS OFFICE					5.01
5.02	00591	A&G HOSPITAL-ONLY					5.02
5.03	00592	A&G SHARED					5.03
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	PERRY PLAZA PLANT OP					7.01
7.02	00702	PROMPT CARE PLANT OP					7.02
7.03	00703	WALNUT CLINIC PLANT OP					7.03
7.04	00704	HENRY CLINIC PLANT OP					7.04
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
9.01	00901	PERRY PLAZA HSKPING					9.01
9.02	00902	PROMPT CARE HSKPING	179				9.02
9.03	00903	WALNUT CLINIC HSKPING	0	108			9.03
9.04	00904	HENRY CLINIC HSKPING	0	0	565		9.04
10.00	01000	DIETARY	0	0	0	89,564	10.00
11.00	01100	CAFETERIA	0	0	0	60,211	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	3	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	21,194	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	3,369	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	2,138	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26	0	0	149	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	6	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	12	17	178	52	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	16	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	0	3	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	708	88.00
88.01	08801	RURAL HEALTH CLINIC II	141	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	04950	SLEEP LAB	0	0	0	32	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	1,683	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	179	17	178	89,564	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	91	387	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	0	0	0	194.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

 Period:
 From 05/01/2020
 To 04/30/2021

 Worksheet B
 Part II
 Date/Time Prepared:
 9/30/2021 1:25 pm

Cost Center Description			PROMPT CARE HSKPING	WALNUT CLINIC HSKPING	HENRY CLINIC HSKPING	DIETARY	CAFETERIA	
			9.02	9.03	9.04	10.00	11.00	
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
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)	179	108	565	89,564	84,784	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	PERRY PLAZA B&F						1.01
1.02	00102	PROMPT CARE						1.02
1.03	00103	WALNUT CLINIC						1.03
1.04	00104	HENRY CLINIC						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	BUSINESS OFFICE						5.01
5.02	00591	A&G HOSPITAL-ONLY						5.02
5.03	00592	A&G SHARED						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	PERRY PLAZA PLANT OP						7.01
7.02	00702	PROMPT CARE PLANT OP						7.02
7.03	00703	WALNUT CLINIC PLANT OP						7.03
7.04	00704	HENRY CLINIC PLANT OP						7.04
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	PERRY PLAZA HSKPING						9.01
9.02	00902	PROMPT CARE HSKPING						9.02
9.03	00903	WALNUT CLINIC HSKPING						9.03
9.04	00904	HENRY CLINIC HSKPING						9.04
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	50,623					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,289	30,959				14.00
15.00	01500	PHARMACY	0	0	56,072			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	87,155		16.00
17.00	01700	SOCIAL SERVICE	0	1	0	0	39,696	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,718	1,398	0	3,249	35,816	30.00
31.00	03100	INTENSIVE CARE UNIT	4,560	307	0	705	3,880	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,592	9,388	0	13,307	0	50.00
53.00	05300	ANESTHESIOLOGY	0	451	0	997	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	50	0	3,969	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	266	0	2,538	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	836	0	56.00
57.00	05700	CT SCAN	0	531	0	10,524	0	57.00
58.00	05800	MRI	0	250	0	2,688	0	58.00
60.00	06000	LABORATORY	0	1,842	0	14,787	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	375	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	263	0	1,335	0	65.00
66.00	06600	PHYSICAL THERAPY	0	293	0	3,606	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	994	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2	0	12	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	12,893	0	1,501	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	56,072	8,241	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	6	0	581	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	37	0	398	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	301	0	4,222	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	274	0	872	0	88.01
90.00	09000	CLINIC	0	423	0	591	0	90.00
90.01	04950	SLEEP LAB	0	66	0	494	0	90.01
90.02	09001	GENERAL SURGERY CL	0	30	0	94	0	90.02
90.03	09002	PM PAIN CLINIC	0	0	0	106	0	90.03
91.00	09100	EMERGENCY	15,464	1,797	0	9,939	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	51	0	194	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,623	30,920	56,072	87,155	39,696	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
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	39	0	0	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
194.03	07953	MOB LEASED SPACE	0	0	0	0	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
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)	50,623	30,959	56,072	87,155	39,696	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	PERRY PLAZA B&F				1.01
1.02	00102	PROMPT CARE				1.02
1.03	00103	WALNUT CLINIC				1.03
1.04	00104	HENRY CLINIC				1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	BUSINESS OFFICE				5.01
5.02	00591	A&G HOSPITAL-ONLY				5.02
5.03	00592	A&G SHARED				5.03
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	PERRY PLAZA PLANT OP				7.01
7.02	00702	PROMPT CARE PLANT OP				7.02
7.03	00703	WALNUT CLINIC PLANT OP				7.03
7.04	00704	HENRY CLINIC PLANT OP				7.04
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
9.01	00901	PERRY PLAZA HSKPING				9.01
9.02	00902	PROMPT CARE HSKPING				9.02
9.03	00903	WALNUT CLINIC HSKPING				9.03
9.04	00904	HENRY CLINIC HSKPING				9.04
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	354,289	0	354,289	30.00
31.00	03100	INTENSIVE CARE UNIT	106,019	0	106,019	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	596,457	0	596,457	50.00
53.00	05300	ANESTHESIOLOGY	63,618	0	63,618	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	419,707	0	419,707	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	65,670	0	65,670	55.00
56.00	05600	RADIOISOTOPE	14,085	0	14,085	56.00
57.00	05700	CT SCAN	34,391	0	34,391	57.00
58.00	05800	MRI	32,152	0	32,152	58.00
60.00	06000	LABORATORY	205,516	0	205,516	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,699	0	4,699	63.00
65.00	06500	RESPIRATORY THERAPY	56,965	0	56,965	65.00
66.00	06600	PHYSICAL THERAPY	108,436	0	108,436	66.00
69.00	06900	ELECTROCARDIOLOGY	11,196	0	11,196	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,682	0	3,682	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,219	0	40,219	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	127,501	0	127,501	73.00
76.00	03140	CARDIOLOGY	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	29,554	0	29,554	76.01
76.97	07697	CARDIAC REHABILITATION	30,806	0	30,806	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	280,632	0	280,632	88.00
88.01	08801	RURAL HEALTH CLINIC II	65,761	0	65,761	88.01
90.00	09000	CLINIC	69,905	0	69,905	90.00
90.01	04950	SLEEP LAB	19,901	0	19,901	90.01
90.02	09001	GENERAL SURGERY CL	19,930	0	19,930	90.02
90.03	09002	PM PAIN CLINIC	16,852	0	16,852	90.03
91.00	09100	EMERGENCY	262,690	0	262,690	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	19,976	0	19,976	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,060,609	0	3,060,609	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,060	0	6,060	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	30,455	0	30,455	194.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
194.01	07951	HOSPITAL LEASED SPACE	22,216	0	22,216		194.01
194.02	07950	PERRY HOME CARE - HHA	141	0	141		194.02
194.03	07953	MOB LEASED SPACE	150,140	0	150,140		194.03
194.05	07955	PERRY PLAZA LEASED	5,180	0	5,180		194.05
194.06	07954	PM PROMPT CARE	0	0	0		194.06
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,274,801	0	3,274,801		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet B-1
Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	PERRY PLAZA B&F (PERRY PLAZA SQ FT)	PROMPT CARE (PROMPT CARE SQ FT)	WALNUT CLINIC (WALNUT CLINIC SQ FT)	HENRY CLINIC (HENRY CLINIC SQ FT)	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	187,338					1.00
1.01	00101	PERRY PLAZA B&F	0	37,714				1.01
1.02	00102	PROMPT CARE	0	0	2,185			1.02
1.03	00103	WALNUT CLINIC	0	0	0	815		1.03
1.04	00104	HENRY CLINIC	0	0	0	0	3,069	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	901	0	0	0	0	4.00
5.01	00590	BUSINESS OFFICE	5,043	0	0	0	0	5.01
5.02	00591	A&G HOSPITAL-ONLY	7,898	233	0	0	0	5.02
5.03	00592	A&G SHARED	15,286	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	23,307	5,813	0	0	0	7.00
7.01	00701	PERRY PLAZA PLANT OP	0	262	0	0	0	7.01
7.02	00702	PROMPT CARE PLANT OP	0	0	364	0	0	7.02
7.03	00703	WALNUT CLINIC PLANT OP	0	0	0	109	0	7.03
7.04	00704	HENRY CLINIC PLANT OP	0	0	0	0	797	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	2,836	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	2,395	0	0	0	0	9.00
9.01	00901	PERRY PLAZA HSKPING	0	0	0	0	0	9.01
9.02	00902	PROMPT CARE HSKPING	0	0	80	0	0	9.02
9.03	00903	WALNUT CLINIC HSKPING	0	0	0	15	0	9.03
9.04	00904	HENRY CLINIC HSKPING	0	0	0	0	122	9.04
10.00	01000	DIETARY	5,266	0	0	0	0	10.00
11.00	01100	CAFETERIA	2,618	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,040	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,841	0	0	0	0	14.00
15.00	01500	PHARMACY	2,356	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,672	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,971	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,450	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,408	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	24,156	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	178	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,813	0	249	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	338	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	589	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	1,282	0	0	0	0	58.00
60.00	06000	LABORATORY	4,017	0	115	107	678	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,042	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,887	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	138	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	342	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
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	1,294	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	1,485	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	8,185	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	1,377	0	0	88.01
90.00	09000	CLINIC	3,566	0	0	0	0	90.00
90.01	04950	SLEEP LAB	1,092	0	0	0	0	90.01
90.02	09001	GENERAL SURGERY CL	1,280	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	1,033	0	0	0	0	90.03
91.00	09100	EMERGENCY	8,302	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	540	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	167,847	6,308	2,185	231	1,597	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	662	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	PERRY PLAZA B&F (PERRY PLAZA SQ FT)	PROMPT CARE (PROMPT CARE SQ FT)	WALNUT CLINIC (WALNUT CLINIC SQ FT)	HENRY CLINIC (HENRY CLINIC SQ FT)	
			1.00	1.01	1.02	1.03	1.04	
194.00	07956	WALNUT & HENRY CLINICS	0	0	0	584	1,472	194.00
194.01	07951	HOSPITAL LEASED SPACE	2,427	0	0	0	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	16,402	0	0	0	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	31,406	0	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
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)	1,367,827	3,788	0	4,133	6,506	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.301386	0.100440	0.000000	5.071166	2.119909	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						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: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description		CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	BUSINESS OFFICE (GROSS REVE NUE)	Reconciliation	A&G HOSPITAL-ONLY (ACCUM. COST)	
		MVBLE EQUIP (DOLLAR VALUE)					
		2.00	4.00	5.01	5A.02	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	PERRY PLAZA B&F					1.01
1.02	00102	PROMPT CARE					1.02
1.03	00103	WALNUT CLINIC					1.03
1.04	00104	HENRY CLINIC					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,816,377				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	14,747,321			4.00
5.01	00590	BUSINESS OFFICE	502	688,879	93,987,750		5.01
5.02	00591	A&G HOSPITAL-ONLY	1,004,169	238,550	0	-3,279,339	5.02
5.03	00592	A&G SHARED	5,679	1,051,469	0	0	5.03
7.00	00700	OPERATION OF PLANT	630	476,811	0	0	7.00
7.01	00701	PERRY PLAZA PLANT OP	30	19,762	0	0	7.01
7.02	00702	PROMPT CARE PLANT OP	0	1,303	0	0	7.02
7.03	00703	WALNUT CLINIC PLANT OP	0	62	0	0	7.03
7.04	00704	HENRY CLINIC PLANT OP	0	410	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	205	0	0	0	8.00
9.00	00900	HOUSEKEEPING	288	261,954	0	0	9.00
9.01	00901	PERRY PLAZA HSKPING	0	0	0	0	9.01
9.02	00902	PROMPT CARE HSKPING	0	1,759	0	0	9.02
9.03	00903	WALNUT CLINIC HSKPING	0	115	0	0	9.03
9.04	00904	HENRY CLINIC HSKPING	0	2,760	0	0	9.04
10.00	01000	DIETARY	11,257	235,293	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	537,308	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,070	45,894	0	0	14.00
15.00	01500	PHARMACY	824	200,568	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,638	566,575	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	333,112	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	36,725	1,002,594	3,504,674	0	30.00
31.00	03100	INTENSIVE CARE UNIT	28,484	361,299	760,508	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	168,972	1,194,686	14,355,229	0	50.00
53.00	05300	ANESTHESIOLOGY	53,825	0	1,075,884	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	288,247	654,599	4,281,550	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	35,739	208,790	2,738,096	0	55.00
56.00	05600	RADIOISOTOPE	0	0	901,702	0	56.00
57.00	05700	CT SCAN	954	44,333	11,353,081	0	57.00
58.00	05800	MRI	2,081	108,420	2,900,107	0	58.00
60.00	06000	LABORATORY	35,232	647,713	15,918,046	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	404,734	0	63.00
65.00	06500	RESPIRATORY THERAPY	10,023	372,284	1,440,424	0	65.00
66.00	06600	PHYSICAL THERAPY	5,984	729,737	3,890,364	0	66.00
69.00	06900	ELECTROCARDIOLOGY	4,811	37,106	1,072,429	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	402	0	12,974	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,618,727	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	8,890,371	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	626,940	0	76.01
76.97	07697	CARDIAC REHABILITATION	9,015	94,478	429,336	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	20,783	2,112,028	4,554,025	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	25,450	578,940	941,068	0	88.01
90.00	09000	CLINIC	11,065	297,990	637,947	0	90.00
90.01	04950	SLEEP LAB	4,393	57,276	532,599	0	90.01
90.02	09001	GENERAL SURGERY CL	0	92,557	101,602	0	90.02
90.03	09002	PM PAIN CLINIC	1,231	55,770	114,519	0	90.03
91.00	09100	EMERGENCY	39,149	1,063,281	10,721,253	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	214,307	209,561	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,813,857	14,590,772	93,987,750	-3,279,339	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	-4,834	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description			CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	BUSINESS OFFICE (GROSS REVE NUE)	Reconciliation	A&G HOSPITAL-ONLY (ACCUM. COST)	
			MVBLE EQUIP (DOLLAR VALUE)					
			2.00	4.00	5.01	5A.02	5.02	
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	2,520	156,549	0	0	378,875	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	-17,720	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	0	0	-119,757	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0	-3,155	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
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)	1,892,547	5,070,379	1,631,482		3,279,339	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.041935	0.343817	0.017358		0.092669	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		6,579	37,651		1,104,073	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000446	0.000401		0.031199	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: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description		Reconciliation	A&G SHARED (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	PERRY PLAZA PLANT OP (PERRY PLAZA SQ. FT)	PROMPT CARE PLANT OP (PROMPT CARE SQ. FT)	
		5A.03	5.03	7.00	7.01	7.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	PERRY PLAZA B&F					1.01
1.02	00102	PROMPT CARE					1.02
1.03	00103	WALNUT CLINIC					1.03
1.04	00104	HENRY CLINIC					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	BUSINESS OFFICE					5.01
5.02	00591	A&G HOSPITAL-ONLY					5.02
5.03	00592	A&G SHARED	-3,314,332	35,498,051			5.03
7.00	00700	OPERATION OF PLANT	0	2,095,045	134,903		7.00
7.01	00701	PERRY PLAZA PLANT OP	0	52,997	0	31,406	7.01
7.02	00702	PROMPT CARE PLANT OP	0	37,698	0	0	7.02
7.03	00703	WALNUT CLINIC PLANT OP	0	13,180	0	0	7.03
7.04	00704	HENRY CLINIC PLANT OP	0	20,980	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	124,750	2,836	0	8.00
9.00	00900	HOUSEKEEPING	0	585,114	2,395	0	9.00
9.01	00901	PERRY PLAZA HSKPING	0	3,194	0	0	9.01
9.02	00902	PROMPT CARE HSKPING	0	3,519	0	0	9.02
9.03	00903	WALNUT CLINIC HSKPING	0	309	0	0	9.03
9.04	00904	HENRY CLINIC HSKPING	0	5,077	0	0	9.04
10.00	01000	DIETARY	0	840,508	5,266	0	10.00
11.00	01100	CAFETERIA	0	20,886	2,618	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	804,341	2,040	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	151,354	1,841	0	14.00
15.00	01500	PHARMACY	0	903,430	2,356	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	954,687	4,672	0	16.00
17.00	01700	SOCIAL SERVICE	0	517,878	1,971	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,873,487	16,450	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	817,342	3,408	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	3,660,378	24,156	0	50.00
53.00	05300	ANESTHESIOLOGY	0	116,812	178	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,746,911	4,813	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	532,617	338	0	55.00
56.00	05600	RADIOISOTOPE	0	212,660	589	0	56.00
57.00	05700	CT SCAN	0	459,751	0	0	57.00
58.00	05800	MRI	0	349,403	1,282	0	58.00
60.00	06000	LABORATORY	0	2,818,590	4,017	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	120,482	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	657,587	2,042	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,227,618	4,887	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	81,367	138	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,728	342	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	728,814	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,726,066	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	471,073	1,294	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	172,400	1,485	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	4,902,950	8,185	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,028,493	0	0	88.01
90.00	09000	CLINIC	0	572,501	3,566	0	90.00
90.01	04950	SLEEP LAB	0	114,866	1,092	0	90.01
90.02	09001	GENERAL SURGERY CL	0	158,056	1,280	0	90.02
90.03	09002	PM PAIN CLINIC	0	119,702	1,033	0	90.03
91.00	09100	EMERGENCY	0	2,763,259	8,302	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	366,740	540	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,314,332	34,938,600	115,412	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,834	662	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	413,985	0	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	17,720	2,427	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description			Reconciliation	A&G SHARED (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	PERRY PLAZA PLANT OP (PERRY PLAZA SQ FT)	PROMPT CARE PLANT OP (PROMPT CARE SQ FT)	
			5A.03	5.03	7.00	7.01	7.02	
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	119,757	16,402	0	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	3,155	0	31,406	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		3,314,332	2,290,653	57,945	41,218	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.093367	16.980000	1.845030	22.634816	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		212,629	243,995	1,896	1,303	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.005990	1.808670	0.060371	0.715541	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: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description		WALNUT CLINIC PLANT OP (WALNUT CLINIC SQ FT)	HENRY CLINIC PLANT OP (HENRY CLINIC SQ FT)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	PERRY PLAZA HSKPING (PERRY PLAZA SQ FT)	
		7.03	7.04	8.00	9.00	9.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	PERRY PLAZA B&F					1.01
1.02	00102	PROMPT CARE					1.02
1.03	00103	WALNUT CLINIC					1.03
1.04	00104	HENRY CLINIC					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	BUSINESS OFFICE					5.01
5.02	00591	A&G HOSPITAL-ONLY					5.02
5.03	00592	A&G SHARED					5.03
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	PERRY PLAZA PLANT OP					7.01
7.02	00702	PROMPT CARE PLANT OP					7.02
7.03	00703	WALNUT CLINIC PLANT OP	706				7.03
7.04	00704	HENRY CLINIC PLANT OP	0	2,272			7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	146,454		8.00
9.00	00900	HOUSEKEEPING	0	0	0	2,408	9.00
9.01	00901	PERRY PLAZA HSKPING	0	0	0	0	31,406
9.02	00902	PROMPT CARE HSKPING	0	0	0	0	0
9.03	00903	WALNUT CLINIC HSKPING	15	0	0	0	0
9.04	00904	HENRY CLINIC HSKPING	0	122	0	0	0
10.00	01000	DIETARY	0	0	0	41	0
11.00	01100	CAFETERIA	0	0	11	0	0
13.00	01300	NURSING ADMINISTRATION	0	0	0	63	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,501	59	0
15.00	01500	PHARMACY	0	0	0	26	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	9	0
17.00	01700	SOCIAL SERVICE	0	0	0	23	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	35,928	505	0
31.00	03100	INTENSIVE CARE UNIT	0	0	5,217	44	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	41,084	473	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	6,456	104	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	5,137	0	0
56.00	05600	RADIOISOTOPE	0	0	816	0	0
57.00	05700	CT SCAN	0	0	5,100	23	0
58.00	05800	MRI	0	0	3,655	21	0
60.00	06000	LABORATORY	107	678	0	83	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	34	0
66.00	06600	PHYSICAL THERAPY	0	0	4,702	53	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03140	CARDIOLOGY	0	0	0	0	0
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	0	37	0
76.97	07697	CARDIAC REHABILITATION	0	0	46	14	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	534	393	0
88.01	08801	RURAL HEALTH CLINIC II	0	0	156	44	0
90.00	09000	CLINIC	0	0	518	1	0
90.01	04950	SLEEP LAB	0	0	0	25	0
90.02	09001	GENERAL SURGERY CL	0	0	232	0	0
90.03	09002	PM PAIN CLINIC	0	0	0	48	0
91.00	09100	EMERGENCY	0	0	32,901	227	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	3	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	122	800	143,994	2,353	0
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0
194.00	07956	WALNUT & HENRY CLINICS	584	1,472	2,460	47	0
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description		WALNUT CLINIC PLANT OP (WALNUT CLINIC SQ FT)	HENRY CLINIC PLANT OP (HENRY CLINIC SQ FT)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	PERRY PLAZA HSPKING (PERRY PLAZA SQ FT)	
		7.03	7.04	8.00	9.00	9.01	
194.02	07950	PERRY HOME CARE - HHA	0	0	8	0	194.02
194.03	07953	MOB LEASED SPACE	0	0	0	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0	31,406	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	194.06
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)	14,411	22,939	184,553	680,411	3,492 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.412181	10.096391	1.260143	282.562708	0.111189 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,008	2,415	30,359	42,448	110 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.427762	1.062940	0.207294	17.627907	0.003503 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: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description		PROMPT CARE HSKPING (PROMPT CARE SQ FT)	WALNUT CLINIC HSKPING (WALNUT CLINIC SQ FT)	HENRY CLINIC HSKPING (HENRY CLINIC SQ FT)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S SERV ED)	
		9.02	9.03	9.04	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	PERRY PLAZA B&F					1.01
1.02	00102	PROMPT CARE					1.02
1.03	00103	WALNUT CLINIC					1.03
1.04	00104	HENRY CLINIC					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	BUSINESS OFFICE					5.01
5.02	00591	A&G HOSPITAL-ONLY					5.02
5.03	00592	A&G SHARED					5.03
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	PERRY PLAZA PLANT OP					7.01
7.02	00702	PROMPT CARE PLANT OP					7.02
7.03	00703	WALNUT CLINIC PLANT OP					7.03
7.04	00704	HENRY CLINIC PLANT OP					7.04
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
9.01	00901	PERRY PLAZA HSKPING					9.01
9.02	00902	PROMPT CARE HSKPING	1,741				9.02
9.03	00903	WALNUT CLINIC HSKPING	0	691			9.03
9.04	00904	HENRY CLINIC HSKPING	0	0	2,150		9.04
10.00	01000	DIETARY	0	0	0	27,565	10.00
11.00	01100	CAFETERIA	0	0	0	18,530	11,945
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	409
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	143
15.00	01500	PHARMACY	0	0	0	0	281
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,191
17.00	01700	SOCIAL SERVICE	0	0	0	1	464
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	6,523	968
31.00	03100	INTENSIVE CARE UNIT	0	0	0	1,037	270
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	658	1,596
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	249	0	0	46	793
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	267
56.00	05600	RADIOISOTOPE	0	0	0	2	0
57.00	05700	CT SCAN	0	0	0	0	60
58.00	05800	MRI	0	0	0	0	135
60.00	06000	LABORATORY	115	107	678	16	976
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	319
66.00	06600	PHYSICAL THERAPY	0	0	0	5	1,066
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	95
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03140	CARDIOLOGY	0	0	0	0	0
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	0	1	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	144
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	218	0
88.01	08801	RURAL HEALTH CLINIC II	1,377	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	646
90.01	04950	SLEEP LAB	0	0	0	10	19
90.02	09001	GENERAL SURGERY CL	0	0	0	0	360
90.03	09002	PM PAIN CLINIC	0	0	0	0	141
91.00	09100	EMERGENCY	0	0	0	518	893
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	269
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,741	107	678	27,565	11,505
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0
194.00	07956	WALNUT & HENRY CLINICS	0	584	1,472	0	440
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description			PROMPT CARE HSKPING (PROMPT CARE SQ FT)	WALNUT CLINIC HSKPING (WALNUT CLINIC SQ FT)	HENRY CLINIC HSKPING (HENRY CLINIC SQ FT)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S SERV ED)	
			9.02	9.03	9.04	10.00	11.00	
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	0	0	0	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
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)	5,659	644	6,783	1,019,986	752,968	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.250431	0.931983	3.154884	37.002939	63.036249	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	179	108	565	89,564	84,784	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.102814	0.156295	0.262791	3.249193	7.097865	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: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (PATIENT DA YS)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	PERRY PLAZA B&F						1.01
1.02	00102	PROMPT CARE						1.02
1.03	00103	WALNUT CLINIC						1.03
1.04	00104	HENRY CLINIC						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	BUSINESS OFFICE						5.01
5.02	00591	A&G HOSPITAL-ONLY						5.02
5.03	00592	A&G SHARED						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	PERRY PLAZA PLANT OP						7.01
7.02	00702	PROMPT CARE PLANT OP						7.02
7.03	00703	WALNUT CLINIC PLANT OP						7.03
7.04	00704	HENRY CLINIC PLANT OP						7.04
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	PERRY PLAZA HSKPING						9.01
9.02	00902	PROMPT CARE HSKPING						9.02
9.03	00903	WALNUT CLINIC HSKPING						9.03
9.04	00904	HENRY CLINIC HSKPING						9.04
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	13,232					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	337	1,534,161				14.00
15.00	01500	PHARMACY	0	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5	0	93,987,750		16.00
17.00	01700	SOCIAL SERVICE	0	71	0	0	2,404	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,847	69,287	0	3,504,674	2,169	30.00
31.00	03100	INTENSIVE CARE UNIT	1,192	15,199	0	760,508	235	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,814	465,209	0	14,355,229	0	50.00
53.00	05300	ANESTHESIOLOGY	0	22,333	0	1,075,884	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,453	0	4,281,550	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	13,188	0	2,738,096	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	901,702	0	56.00
57.00	05700	CT SCAN	0	26,321	0	11,353,081	0	57.00
58.00	05800	MRI	0	12,373	0	2,900,107	0	58.00
60.00	06000	LABORATORY	0	91,287	0	15,918,046	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	404,734	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	13,032	0	1,440,424	0	65.00
66.00	06600	PHYSICAL THERAPY	0	14,542	0	3,890,364	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,072,429	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	82	0	12,974	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	638,905	0	1,618,727	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	8,890,371	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	277	0	626,940	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	1,841	0	429,336	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	14,939	0	4,554,025	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	13,580	0	941,068	0	88.01
90.00	09000	CLINIC	0	20,941	0	637,947	0	90.00
90.01	04950	SLEEP LAB	0	3,261	0	532,599	0	90.01
90.02	09001	GENERAL SURGERY CL	0	1,505	0	101,602	0	90.02
90.03	09002	PM PAIN CLINIC	0	0	0	114,519	0	90.03
91.00	09100	EMERGENCY	4,042	89,064	0	10,721,253	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	2,551	0	209,561	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,232	1,532,246	100	93,987,750	2,404	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
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	1,915	0	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet B-1

Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (PATIENT DA YS)	
			13.00	14.00	15.00	16.00	17.00	
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	0	0	0	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
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)	957,662	248,711	1,052,846	1,200,774	635,496	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	72.374698	0.162115	10,528.460000	0.012776	264.349418	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	50,623	30,959	56,072	87,155	39,696	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.825801	0.020180	560.720000	0.000927	16.512479	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: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/30/2021 1:25 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,725,892		3,725,892	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,186,495		1,186,495	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,257,543		5,257,543	0	0	50.00
53.00	05300	ANESTHESIOLOGY	148,106		148,106	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,142,496		2,142,496	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	648,509		648,509	0	0	55.00
56.00	05600	RADIOISOTOPE	255,138		255,138	0	0	56.00
57.00	05700	CT SCAN	668,699		668,699	0	0	57.00
58.00	05800	MRI	461,902		461,902	0	0	58.00
60.00	06000	LABORATORY	3,467,932		3,467,932	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	136,902		136,902	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	803,889	0	803,889	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,565,561	0	1,565,561	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	110,996		110,996	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,062		10,062	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	921,117		921,117	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,053,653		3,053,653	0	0	73.00
76.00	03140	CARDIOLOGY	0		0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	555,575		555,575	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	232,585		232,585	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,680,080		5,680,080	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,187,019		1,187,019	0	0	88.01
90.00	09000	CLINIC	739,707		739,707	0	0	90.00
90.01	04950	SLEEP LAB	160,098		160,098	0	0	90.01
90.02	09001	GENERAL SURGERY CL	219,074		219,074	0	0	90.02
90.03	09002	PM PAIN CLINIC	172,332		172,332	0	0	90.03
91.00	09100	EMERGENCY	3,787,238		3,787,238	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,100,876		1,100,876		0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	431,046		431,046		0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	38,830,522	0	38,830,522	0	0	200.00
201.00		Less Observation Beds	1,100,876		1,100,876			201.00
202.00		Total (see instructions)	37,729,646	0	37,729,646	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/30/2021 1:25 pm

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,334,107		2,334,107		30.00
31.00	03100	INTENSIVE CARE UNIT	760,508		760,508		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,139,311	12,215,918	14,355,229	0.366246	0.000000
53.00	05300	ANESTHESIOLOGY	173,832	902,052	1,075,884	0.137660	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	287,197	3,994,353	4,281,550	0.500402	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	62,059	2,676,037	2,738,096	0.236847	0.000000
56.00	05600	RADIOISOTOPE	37,226	864,476	901,702	0.282952	0.000000
57.00	05700	CT SCAN	528,536	10,824,545	11,353,081	0.058900	0.000000
58.00	05800	MRI	94,774	2,805,333	2,900,107	0.159271	0.000000
60.00	06000	LABORATORY	1,294,668	14,623,378	15,918,046	0.217862	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	69,660	335,074	404,734	0.338252	0.000000
65.00	06500	RESPIRATORY THERAPY	934,136	506,288	1,440,424	0.558092	0.000000
66.00	06600	PHYSICAL THERAPY	500,156	3,390,208	3,890,364	0.402420	0.000000
69.00	06900	ELECTROCARDIOLOGY	51,714	1,020,715	1,072,429	0.103500	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	12,974	12,974	0.775551	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	601,140	1,017,587	1,618,727	0.569038	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,412,782	7,477,590	8,890,372	0.343479	0.000000
76.00	03140	CARDIOLOGY	0	0	0	0.000000	0.000000
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	626,940	626,940	0.886169	0.000000
76.97	07697	CARDIAC REHABILITATION	0	429,336	429,336	0.541732	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	36,673	4,517,352	4,554,025		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	941,068	941,068		88.01
90.00	09000	CLINIC	0	637,947	637,947	1.159512	0.000000
90.01	04950	SLEEP LAB	0	532,599	532,599	0.300598	0.000000
90.02	09001	GENERAL SURGERY CL	0	101,602	101,602	2.156198	0.000000
90.03	09002	PM PAIN CLINIC	0	114,519	114,519	1.504833	0.000000
91.00	09100	EMERGENCY	324,761	10,396,492	10,721,253	0.353246	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,757	1,163,810	1,170,567	0.940464	0.000000
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	209,561	209,561		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	11,649,997	82,337,754	93,987,751		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	11,649,997	82,337,754	93,987,751		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
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
76.00	03140	CARDIOLOGY	0.000000			76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0.000000			76.01
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
90.00	09000	CLINIC	0.000000			90.00
90.01	04950	SLEEP LAB	0.000000			90.01
90.02	09001	GENERAL SURGERY CL	0.000000			90.02
90.03	09002	PM PAIN CLINIC	0.000000			90.03
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/30/2021 1:25 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,725,892		3,725,892	0	3,725,892	30.00
31.00	03100	INTENSIVE CARE UNIT	1,186,495		1,186,495	0	1,186,495	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,257,543		5,257,543	0	5,257,543	50.00
53.00	05300	ANESTHESIOLOGY	148,106		148,106	0	148,106	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,142,496		2,142,496	0	2,142,496	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	648,509		648,509	0	648,509	55.00
56.00	05600	RADIOISOTOPE	255,138		255,138	0	255,138	56.00
57.00	05700	CT SCAN	668,699		668,699	0	668,699	57.00
58.00	05800	MRI	461,902		461,902	0	461,902	58.00
60.00	06000	LABORATORY	3,467,932		3,467,932	0	3,467,932	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	136,902		136,902	0	136,902	63.00
65.00	06500	RESPIRATORY THERAPY	803,889	0	803,889	0	803,889	65.00
66.00	06600	PHYSICAL THERAPY	1,565,561	0	1,565,561	0	1,565,561	66.00
69.00	06900	ELECTROCARDIOLOGY	110,996		110,996	0	110,996	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,062		10,062	0	10,062	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	921,117		921,117	0	921,117	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,053,653		3,053,653	0	3,053,653	73.00
76.00	03140	CARDIOLOGY	0		0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	555,575		555,575	0	555,575	76.01
76.97	07697	CARDIAC REHABILITATION	232,585		232,585	0	232,585	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,680,080		5,680,080	0	5,680,080	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,187,019		1,187,019	0	1,187,019	88.01
90.00	09000	CLINIC	739,707		739,707	0	739,707	90.00
90.01	04950	SLEEP LAB	160,098		160,098	0	160,098	90.01
90.02	09001	GENERAL SURGERY CL	219,074		219,074	0	219,074	90.02
90.03	09002	PM PAIN CLINIC	172,332		172,332	0	172,332	90.03
91.00	09100	EMERGENCY	3,787,238		3,787,238	0	3,787,238	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,100,876		1,100,876	0	1,100,876	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	431,046		431,046		431,046	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	38,830,522	0	38,830,522	0	38,830,522	200.00
201.00		Less Observation Beds	1,100,876		1,100,876		1,100,876	201.00
202.00		Total (see instructions)	37,729,646	0	37,729,646	0	37,729,646	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/30/2021 1:25 pm

			Title XIX			Hospital	Cost		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,334,107		2,334,107			30.00	
31.00	03100	INTENSIVE CARE UNIT	760,508		760,508			31.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,139,311	12,215,918	14,355,229	0.366246	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	173,832	902,052	1,075,884	0.137660	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	287,197	3,994,353	4,281,550	0.500402	0.000000	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	62,059	2,676,037	2,738,096	0.236847	0.000000	55.00	
56.00	05600	RADIOISOTOPE	37,226	864,476	901,702	0.282952	0.000000	56.00	
57.00	05700	CT SCAN	528,536	10,824,545	11,353,081	0.058900	0.000000	57.00	
58.00	05800	MRI	94,774	2,805,333	2,900,107	0.159271	0.000000	58.00	
60.00	06000	LABORATORY	1,294,668	14,623,378	15,918,046	0.217862	0.000000	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	69,660	335,074	404,734	0.338252	0.000000	63.00	
65.00	06500	RESPIRATORY THERAPY	934,136	506,288	1,440,424	0.558092	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	500,156	3,390,208	3,890,364	0.402420	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	51,714	1,020,715	1,072,429	0.103500	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	12,974	12,974	0.775551	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	601,140	1,017,587	1,618,727	0.569038	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,412,782	7,477,590	8,890,372	0.343479	0.000000	73.00	
76.00	03140	CARDIOLOGY	0	0	0	0.000000	0.000000	76.00	
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	626,940	626,940	0.886169	0.000000	76.01	
76.97	07697	CARDIAC REHABILITATION	0	429,336	429,336	0.541732	0.000000	76.97	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	36,673	4,517,352	4,554,025	1.247266	0.000000	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	941,068	941,068	1.261353	0.000000	88.01	
90.00	09000	CLINIC	0	637,947	637,947	1.159512	0.000000	90.00	
90.01	04950	SLEEP LAB	0	532,599	532,599	0.300598	0.000000	90.01	
90.02	09001	GENERAL SURGERY CL	0	101,602	101,602	2.156198	0.000000	90.02	
90.03	09002	PM PAIN CLINIC	0	114,519	114,519	1.504833	0.000000	90.03	
91.00	09100	EMERGENCY	324,761	10,396,492	10,721,253	0.353246	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,757	1,163,810	1,170,567	0.940464	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	209,561	209,561			101.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	11,649,997	82,337,754	93,987,751			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	11,649,997	82,337,754	93,987,751			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
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
76.00	03140	CARDIOLOGY	0.000000			76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0.000000			76.01
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
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
90.00	09000	CLINIC	0.000000			90.00
90.01	04950	SLEEP LAB	0.000000			90.01
90.02	09001	GENERAL SURGERY CL	0.000000			90.02
90.03	09002	PM PAIN CLINIC	0.000000			90.03
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-1337		Period: From 05/01/2020 To 04/30/2021		Worksheet D Part II Date/Time Prepared: 9/30/2021 1:25 pm	
				Title XVIII		Hospital		Cost	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	596,457	14,355,229	0.041550	1,119,400	46,511	50.00	
53.00	05300	ANESTHESIOLOGY	63,618	1,075,884	0.059131	85,324	5,045	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	419,707	4,281,550	0.098027	148,878	14,594	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	65,670	2,738,096	0.023984	58,241	1,397	55.00	
56.00	05600	RADIOISOTOPE	14,085	901,702	0.015620	20,723	324	56.00	
57.00	05700	CT SCAN	34,391	11,353,081	0.003029	106,921	324	57.00	
58.00	05800	MRI	32,152	2,900,107	0.011086	35,720	396	58.00	
60.00	06000	LABORATORY	205,516	15,918,046	0.012911	625,068	8,070	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,699	404,734	0.011610	46,384	539	63.00	
65.00	06500	RESPIRATORY THERAPY	56,965	1,440,424	0.039547	571,239	22,591	65.00	
66.00	06600	PHYSICAL THERAPY	108,436	3,890,364	0.027873	186,854	5,208	66.00	
69.00	06900	ELECTROCARDIOLOGY	11,196	1,072,429	0.010440	16,562	173	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	3,682	12,974	0.283798	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,219	1,618,727	0.024846	292,481	7,267	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	127,501	8,890,372	0.014341	734,552	10,534	73.00	
76.00	03140	CARDIOLOGY	0	0	0.000000	0	0	76.00	
76.01	03950	SENIOR BEHAVIORAL WELLNESS	29,554	626,940	0.047140	0	0	76.01	
76.97	07697	CARDIAC REHABILITATION	30,806	429,336	0.071753	0	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	280,632	4,554,025	0.061623	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	65,761	941,068	0.069879	0	0	88.01	
90.00	09000	CLINIC	69,905	637,947	0.109578	0	0	90.00	
90.01	04950	SLEEP LAB	19,901	532,599	0.037366	0	0	90.01	
90.02	09001	GENERAL SURGERY CL	19,930	101,602	0.196158	0	0	90.02	
90.03	09002	PM PAIN CLINIC	16,852	114,519	0.147155	0	0	90.03	
91.00	09100	EMERGENCY	262,690	10,721,253	0.024502	8,121	199	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	104,680	1,170,567	0.089427	0	0	92.00	
200.00		Total (lines 50 through 199)	2,685,005	90,683,575		4,056,468	123,172	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet D
Part IV
Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	SLEEP LAB	0	0	0	0	0	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	0	0	0	0	0	90.03
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
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: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part IV
Date/Time Prepared:
9/30/2021 1:25 pm

			Title XVIII		Hospital	Cost		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	14,355,229	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,075,884	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,281,550	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	2,738,096	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	901,702	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	11,353,081	0.000000	57.00
58.00	05800	MRI	0	0	0	2,900,107	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	15,918,046	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	404,734	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,440,424	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,890,364	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,072,429	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	12,974	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,618,727	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,890,372	0.000000	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0.000000	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	0	626,940	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	429,336	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,554,025	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	941,068	0.000000	88.01
90.00	09000	CLINIC	0	0	0	637,947	0.000000	90.00
90.01	04950	SLEEP LAB	0	0	0	532,599	0.000000	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	101,602	0.000000	90.02
90.03	09002	PM PAIN CLINIC	0	0	0	114,519	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	10,721,253	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,170,567	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	90,683,575		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part IV
Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			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	1,119,400	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	85,324	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	148,878	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	58,241	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	20,723	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	106,921	0	0	0	57.00
58.00	05800	MRI	0.000000	35,720	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	625,068	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	46,384	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	571,239	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	186,854	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	16,562	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	292,481	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	734,552	0	0	0	73.00
76.00	03140	CARDIOLOGY	0.000000	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
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
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	SLEEP LAB	0.000000	0	0	0	0	90.01
90.02	09001	GENERAL SURGERY CL	0.000000	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	8,121	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,056,468	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part V
Date/Time Prepared:
9/30/2021 1:25 pm

			Title XVIII		Hospital		Cost	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.366246	0	4,908,312	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.137660	0	308,346	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.500402	0	1,323,961	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.236847	0	1,284,056	0	0	55.00
56.00	05600	RADIOISOTOPE	0.282952	0	422,839	0	0	56.00
57.00	05700	CT SCAN	0.058900	0	4,362,994	0	0	57.00
58.00	05800	MRI	0.159271	0	1,105,996	0	0	58.00
60.00	06000	LABORATORY	0.217862	0	5,888,675	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.338252	0	231,083	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.558092	0	242,560	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.402420	0	1,213,229	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.103500	0	455,515	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.775551	0	3,992	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.569038	0	208,701	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343479	0	4,386,072	396	0	73.00
76.00	03140	CARDIOLOGY	0.000000	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0.886169	0	472,388	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.541732	0	223,122	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	1.159512	0	145,133	180	0	90.00
90.01	04950	SLEEP LAB	0.300598	0	157,688	0	0	90.01
90.02	09001	GENERAL SURGERY CL	2.156198	0	21,938	0	0	90.02
90.03	09002	PM PAIN CLINIC	1.504833	0	37,458	0	0	90.03
91.00	09100	EMERGENCY	0.353246	0	3,515,509	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.940464	0	546,733	0	0	92.00
200.00		Subtotal (see instructions)		0	31,466,300	576	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	31,466,300	576	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part V
Date/Time Prepared:
9/30/2021 1:25 pm

			Title XVIII		Hospital	Cost
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,797,650	0		50.00
53.00	05300	ANESTHESIOLOGY	42,447	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	662,513	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	304,125	0		55.00
56.00	05600	RADIOISOTOPE	119,643	0		56.00
57.00	05700	CT SCAN	256,980	0		57.00
58.00	05800	MRI	176,153	0		58.00
60.00	06000	LABORATORY	1,282,919	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	78,164	0		63.00
65.00	06500	RESPIRATORY THERAPY	135,371	0		65.00
66.00	06600	PHYSICAL THERAPY	488,228	0		66.00
69.00	06900	ELECTROCARDIOLOGY	47,146	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,096	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	118,759	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,506,524	136		73.00
76.00	03140	CARDIOLOGY	0	0		76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	418,616	0		76.01
76.97	07697	CARDIAC REHABILITATION	120,872	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
90.00	09000	CLINIC	168,283	209		90.00
90.01	04950	SLEEP LAB	47,401	0		90.01
90.02	09001	GENERAL SURGERY CL	47,303	0		90.02
90.03	09002	PM PAIN CLINIC	56,368	0		90.03
91.00	09100	EMERGENCY	1,241,839	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	514,183	0		92.00
200.00		Subtotal (see instructions)	9,634,583	345		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	9,634,583	345		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1337

Period:

Worksheet D

Component CCN: 14-Z337

From 05/01/2020
To 04/30/2021Part V
Date/Time Prepared:
9/30/2021 1:25 pm

			Title XVIII	Swing Beds - SNF		Cost	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.366246	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.137660	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.500402	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.236847	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.282952	0	0	0	56.00
57.00	05700	CT SCAN	0.058900	0	0	0	57.00
58.00	05800	MRI	0.159271	0	0	0	58.00
60.00	06000	LABORATORY	0.217862	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.338252	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.558092	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.402420	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.103500	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.775551	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.569038	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343479	0	0	0	73.00
76.00	03140	CARDIOLOGY	0.000000	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0.886169	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.541732	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC					88.00
88.01	08801	RURAL HEALTH CLINIC II					88.01
90.00	09000	CLINIC	1.159512	0	0	0	90.00
90.01	04950	SLEEP LAB	0.300598	0	0	0	90.01
90.02	09001	GENERAL SURGERY CL	2.156198	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	1.504833	0	0	0	90.03
91.00	09100	EMERGENCY	0.353246	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.940464	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0	201.00
		Only Charges					
202.00		Net Charges (line 200 - line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1337

Period:

Worksheet D

Component CCN: 14-Z337

From 05/01/2020
To 04/30/2021Part V
Date/Time Prepared:
9/30/2021 1:25 pm

			Title XVIII		Swing Beds - SNF		Cost		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0					50.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0					55.00
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
60.00	06000	LABORATORY	0	0					60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0					63.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
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
76.00	03140	CARDIOLOGY	0	0					76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0					76.01
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC							88.00
88.01	08801	RURAL HEALTH CLINIC II							88.01
90.00	09000	CLINIC	0	0					90.00
90.01	04950	SLEEP LAB	0	0					90.01
90.02	09001	GENERAL SURGERY CL	0	0					90.02
90.03	09002	PM PAIN CLINIC	0	0					90.03
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
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: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet D-1

Date/Time Prepared:
9/30/2021 1:25 pm

Title XVIII		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,169	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,929	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)	1,290	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	155	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)	78	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	5	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)	2	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	814	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)	151	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)	76	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	169.71	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	169.71	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,725,892	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)	849	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)	339	25.00
26.00	Total swing-bed cost (see instructions)	402,600	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,323,292	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,323,292	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)	1,722.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,402,359	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)	1,402,359	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet D-1

Date/Time Prepared:
9/30/2021 1:25 pm

		Title XVIII		Hospital	Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,186,495	235	5,048.91	138	696,750
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,497,051
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,596,160
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					260,143
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					130,933
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					391,076
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					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)					639
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,722.81
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,100,876

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet D-1

Date/Time Prepared:
9/30/2021 1:25 pm

		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	354,289	3,725,892	0.095088	1,100,876	104,680	90.00
91.00	Nursing School cost	0	3,725,892	0.000000	1,100,876	0	91.00
92.00	Allied health cost	0	3,725,892	0.000000	1,100,876	0	92.00
93.00	All other Medical Education	0	3,725,892	0.000000	1,100,876	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1337	Period: From 05/01/2020 To 04/30/2021	Worksheet D-3 Date/Time Prepared: 9/30/2021 1:25 pm
			Title XVIII	Hospital	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,351,694	30.00
31.00	03100	INTENSIVE CARE UNIT		456,435	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.366246	1,119,400	50.00
53.00	05300	ANESTHESIOLOGY	0.137660	85,324	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.500402	148,878	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.236847	58,241	55.00
56.00	05600	RADIOISOTOPE	0.282952	20,723	56.00
57.00	05700	CT SCAN	0.058900	106,921	57.00
58.00	05800	MRI	0.159271	35,720	58.00
60.00	06000	LABORATORY	0.217862	625,068	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.338252	46,384	63.00
65.00	06500	RESPIRATORY THERAPY	0.558092	571,239	65.00
66.00	06600	PHYSICAL THERAPY	0.402420	186,854	66.00
69.00	06900	ELECTROCARDIOLOGY	0.103500	16,562	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.775551	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.569038	292,481	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343479	734,552	73.00
76.00	03140	CARDIOLOGY	0.000000	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0.886169	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.541732	0	76.97
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
90.00	09000	CLINIC	1.159512	0	90.00
90.01	04950	SLEEP LAB	0.300598	0	90.01
90.02	09001	GENERAL SURGERY CL	2.156198	0	90.02
90.03	09002	PM PAIN CLINIC	1.504833	0	90.03
91.00	09100	EMERGENCY	0.353246	8,121	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.940464	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,056,468	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)		4,056,468	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1337	Period: From 05/01/2020 To 04/30/2021	Worksheet D-3
			Component CCN: 14-Z337		Date/Time Prepared: 9/30/2021 1:25 pm
			Title XVIII	Swing Beds - SNF	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		2,396	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.366246	3,761	50.00
53.00	05300	ANESTHESIOLOGY	0.137660	664	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.500402	11,739	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.236847	1,095	55.00
56.00	05600	RADIOISOTOPE	0.282952	2,821	56.00
57.00	05700	CT SCAN	0.058900	14,227	57.00
58.00	05800	MRI	0.159271	8,723	58.00
60.00	06000	LABORATORY	0.217862	40,178	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.338252	690	63.00
65.00	06500	RESPIRATORY THERAPY	0.558092	46,841	65.00
66.00	06600	PHYSICAL THERAPY	0.402420	176,095	66.00
69.00	06900	ELECTROCARDIOLOGY	0.103500	1,014	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.775551	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.569038	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.343479	52,098	73.00
76.00	03140	CARDIOLOGY	0.000000	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0.886169	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.541732	0	76.97
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
90.00	09000	CLINIC	1.159512	0	90.00
90.01	04950	SLEEP LAB	0.300598	0	90.01
90.02	09001	GENERAL SURGERY CL	2.156198	0	90.02
90.03	09002	PM PAIN CLINIC	1.504833	0	90.03
91.00	09100	EMERGENCY	0.353246	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.940464	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		359,946	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)		359,946	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1337	Period: From 05/01/2020 To 04/30/2021	Worksheet E Part B Date/Time Prepared: 9/30/2021 1:25 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			9,634,928 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	OPPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			9,634,928 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			9,731,277 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			81,634 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			5,094,731 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)			4,554,912 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)			4,554,912 30.00
31.00	Primary payer payments			4,100 31.00
32.00	Subtotal (line 30 minus line 31)			4,550,812 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)			580,418 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			377,272 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			461,748 36.00
37.00	Subtotal (see instructions)			4,928,084 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			4,928,084 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			5,240,853 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)			-312,769 43.00
43.01	Balance due provider/program-PARHM (see instructions)			0 43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet E-1
Part I
Date/Time Prepared:
9/30/2021 1:25 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,160,923		5,296,297	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	12/29/2020	161,011		0	3.01
3.02		04/15/2021	62,774		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	12/29/2020	55,444	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)		223,785		-55,444	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,384,708		5,240,853	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		60,059		312,769	6.02
7.00	Total Medicare program liability (see instructions)		3,324,649		4,928,084	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: 14-1337

Period:

Worksheet E-1

Component CCN: 14-Z337

From 05/01/2020
To 04/30/2021Part I
Date/Time Prepared:
9/30/2021 1:25 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		489,421		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	12/29/2020	29,892		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)		29,892		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)		519,313		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		7,062		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		526,375		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-1337	Period: From 05/01/2020 To 04/30/2021	Worksheet E-1 Part II Date/Time Prepared: 9/30/2021 1:25 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1337

Period:

Worksheet E-2

Component CCN: 14-Z337

From 05/01/2020

Date/Time Prepared:

To 04/30/2021

9/30/2021 1:25 pm

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		394,987	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)		135,964	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		227	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)		530,951	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		530,951	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)		530,951	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		4,576	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		526,375	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)		526,375	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		519,313	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)		7,062	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparision of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1337	Period: From 05/01/2020 To 04/30/2021	Worksheet E-3 Part V Date/Time Prepared: 9/30/2021 1:25 pm
		Title XVIII	Hospital	Cost
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		3,596,160	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		3,596,160	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		3,596,160	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		3,596,160	19.00
20.00	Deductibles (exclude professional component)		313,064	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		3,283,096	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		3,283,096	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		63,927	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		41,553	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		48,808	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		3,324,649	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		3,324,649	30.00
30.01	Sequestration adjustment (see instructions)		0	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM			30.03
31.00	Interim payments		3,384,708	31.00
31.01	Interim payments-PARHM			31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)			32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		-60,059	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)			33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet G

Date/Time Prepared:
9/30/2021 1:25 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	7,973,882	0	0	0	1.00
2.00	Temporary investments	2,843,916	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,667,326	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	417,261	0	0	0	7.00
8.00	Prepaid expenses	599,043	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	18,501,428	0	0	0	11.00
FIXED ASSETS						
12.00	Land	897,170	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	17,598,973	0	0	0	15.00
16.00	Accumulated depreciation	0	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	18,496,143	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	192,397	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	1,949,449	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,141,846	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	39,139,417	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,398,537	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,764,532	0	0	0	38.00
39.00	Payroll taxes payable	1,000,062	0	0	0	39.00
40.00	Notes and loans payable (short term)	510,916	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	6,380,030	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	73,811	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,127,888	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	3,646,140	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	5,433,398	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,079,538	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	20,207,426	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	18,931,991	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	18,931,991	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	39,139,417	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet G-1

Date/Time Prepared:
9/30/2021 1:25 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		22,647,002		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		274,189				2.00
3.00	Total (sum of line 1 and line 2)		22,921,191		0		3.00
4.00	ROUNDING	1,000		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)		1,000		0		10.00
11.00	Subtotal (line 3 plus line 10)		22,922,191		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		22,922,191		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	ROUNDING		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,795,616		3,795,616	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	238,997		238,997	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)	4,034,613		4,034,613	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	525,802		525,802	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)	525,802		525,802	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,560,415		4,560,415	17.00
18.00	Ancillary services	9,115,779	77,288,995	86,404,774	18.00
19.00	Outpatient services	498,914	4,429,406	4,928,320	19.00
20.00	RURAL HEALTH CLINIC	47,833	4,224,527	4,272,360	20.00
20.01	RURAL HEALTH CLINIC II	0	1,300,189	1,300,189	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		38,944	38,944	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER NRCC	232	443,879	444,111	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	14,223,173	87,725,940	101,949,113	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		44,022,835		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)		44,022,835		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1337

Period:
From 05/01/2020
To 04/30/2021

Worksheet G-3

Date/Time Prepared:
9/30/2021 1:25 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	101,949,113	1.00
2.00	Less contractual allowances and discounts on patients' accounts	61,053,994	2.00
3.00	Net patient revenues (line 1 minus line 2)	40,895,119	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	44,022,835	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,127,716	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	508,399	6.00
7.00	Income from investments	138,295	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	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	0	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	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	PROVIDER RELIEF FUND	2,699,344	24.00
24.01	OTHER OPERATING INCOME	419,815	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	3,765,853	25.00
26.00	Total (line 5 plus line 25)	638,137	26.00
27.00	OTHER NON-OP	363,948	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	363,948	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	274,189	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1337

Period:

Worksheet H

HHA CCN: 14-7151

From 05/01/2020

To 04/30/2021

Date/Time Prepared:
9/30/2021 1:25 pm

		Home Health Agency I					
		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)
		1.00	2.00	3.00	4.00	5.00	6.00
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0
2.00	Capital Related - Movable Equipment			0		0	0
3.00	Plant Operation & Maintenance	0	0	0	0	0	0
4.00	Transportation	0	0	0	0	0	0
5.00	Administrative and General	0	0	0	0	0	0
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	214,307	0	0	0	40,067	254,374
7.00	Physical Therapy	0	0	0	0	0	0
8.00	Occupational Therapy	0	0	0	0	0	0
9.00	Speech Pathology	0	0	0	0	0	0
10.00	Medical Social Services	0	0	0	0	0	0
11.00	Home Health Aide	0	0	0	0	0	0
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	214,307	0	0	0	40,067	254,374
		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)		
		7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	254,374	0	254,374		6.00
7.00	Physical Therapy	0	0	0	0		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Home Health Aide	0	0	0	0		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Telemedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	0	254,374	0	254,374		24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-1337

Period:

Worksheet H-1

HHA CCN: 14-7151

From 05/01/2020
To 04/30/2021Part I
Date/Time Prepared:
9/30/2021 1:25 pmHome Health
Agency I

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
			0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	0	0	0	0	0	0	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	254,374	0	0	0	0	254,374	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	254,374	0	0	0	0	254,374	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	0						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	254,374					6.00
7.00	Physical Therapy	0	0					7.00
8.00	Occupational Therapy	0	0					8.00
9.00	Speech Pathology	0	0					9.00
10.00	Medical Social Services	0	0					10.00
11.00	Home Health Aide	0	0					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		254,374					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-1337

Period:

Worksheet H-1

HHA CCN: 14-7151

From 05/01/2020
To 04/30/2021Part II
Date/Time Prepared:
9/30/2021 1:25 pmHome Health
Agency I

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	254,374	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	254,374	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	254,374	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	0	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1337

Period:

Worksheet H-2

HHA CCN: 14-7151

From 05/01/2020
To 04/30/2021Part I
Date/Time Prepared:
9/30/2021 1:25 pmHome Health
Agency I

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS				HENRY CLINIC	
			BLDG & FIXT	PERRY PLAZA B&F	PROMPT CARE	WALNUT CLINIC		
		0	1.00	1.01	1.02	1.03	1.04	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	254,374	3,943	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	254,374	3,943	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

Cost Center Description		CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	BUSINESS OFFICE	Subtotal	A&G HOSPITAL - ONLY	Subtotal	
		MVBLE EQUIP						
		2.00						
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	73,682	3,638	335,637	31,103	366,740	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	73,682	3,638	335,637	31,103	366,740	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000		0.000000	21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1337

Period:

Worksheet H-2

HHA CCN: 14-7151

From 05/01/2020
To 04/30/2021Part I
Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description		A&G SHARED	OPERATION OF PLANT	PERRY PLAZA PLANT OP	PROMPT CARE PLANT OP	WALNUT CLINIC PLANT OP	HENRY CLINIC PLANT OP	
		5.03	7.00	7.01	7.02	7.03	7.04	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	34,241	9,169	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	34,241	9,169	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	PERRY PLAZA HSKPING	PROMPT CARE HSKPING	WALNUT CLINIC HSKPING	HENRY CLINIC HSKPING	
		8.00	9.00	9.01	9.02	9.03	9.04	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	848	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	848	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1337

Period:

Worksheet H-2

HHA CCN: 14-7151

From 05/01/2020
To 04/30/2021Part I
Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	16,957	0	414	0	2,677	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	16,957	0	414	0	2,677	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		17.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	431,046	0	431,046	0	431,046	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	431,046	0	431,046	0	431,046	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1337

Period:

Worksheet H-2

HHA CCN: 14-7151

From 05/01/2020
To 04/30/2021Part II
Date/Time Prepared:
9/30/2021 1:25 pmHome Health
Agency I

Cost Center Description		CAPITAL RELATED COSTS						
		BLDG & FIXT (SQUARE FEET)	PERRY PLAZA B&F (PERRY PLAZA SQ FT)	PROMPT CARE (PROMPT CARE SQ FT)	WALNUT CLINIC (WALNUT CLINIC SQ FT)	HENRY CLINIC (HENRY CLINIC SQ FT)	MVBLE EQUIP (DOLLAR VALUE)	
		1.00	1.01	1.02	1.03	1.04	2.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	540	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	540	0	0	0	0	0	20.00
21.00	Total cost to be allocated	3,943	0	0	0	0	0	21.00
22.00	Unit cost multiplier	7.301852	0.000000	0.000000	0.000000	0.000000	0.000000	22.00
Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	BUSINESS OFFICE (GROSS REVE NUE)	Reconciliation	A&G HOSPITAL-ONLY (ACCUM. COST)	Reconciliation	A&G SHARED (ACCUM. COST)	
		4.00	5.01	5A.02	5.02	5A.03	5.03	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	214,307	209,561	0	335,637	0	366,740	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	214,307	209,561		335,637		366,740	20.00
21.00	Total cost to be allocated	73,682	3,638		31,103		34,241	21.00
22.00	Unit cost multiplier	0.343815	0.017360		0.092669		0.093366	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1337

Period:

Worksheet H-2

HHA CCN: 14-7151

From 05/01/2020
To 04/30/2021Part II
Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	PERRY PLAZA PLANT OP (PERRY PLAZA SQ FT)	PROMPT CARE PLANT OP (PROMPT CARE SQ FT)	WALNUT CLINIC PLANT OP (WALNUT CLINIC SQ FT)	HENRY CLINIC PLANT OP (HENRY CLINIC SQ FT)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		7.00	7.01	7.02	7.03	7.04	8.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	540	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	540	0	0	0	0	0	20.00
21.00	Total cost to be allocated	9,169	0	0	0	0	0	21.00
22.00	Unit cost multiplier	16.979630	0.000000	0.000000	0.000000	0.000000	0.000000	22.00
Cost Center Description		HOUSEKEEPING (HOURS OF SERVICE)	PERRY PLAZA HSKPING (PERRY PLAZA SQ FT)	PROMPT CARE HSKPING (PROMPT CARE SQ FT)	WALNUT CLINIC HSKPING (WALNUT CLINIC SQ FT)	HENRY CLINIC HSKPING (HENRY CLINIC SQ FT)	DIETARY (MEALS SERVED)	
		9.00	9.01	9.02	9.03	9.04	10.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	3	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	3	0	0	0	0	0	20.00
21.00	Total cost to be allocated	848	0	0	0	0	0	21.00
22.00	Unit cost multiplier	282.666667	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1337

Period:

Worksheet H-2

HHA CCN: 14-7151

From 05/01/2020
To 04/30/2021Part II
Date/Time Prepared:
9/30/2021 1:25 pm

Cost Center Description		Home Health Agency I					
		CAFETERIA (FTE'S SERVED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)
		11.00	13.00	14.00	15.00	16.00	17.00
1.00	Administrative and General	0	0	0	0	0	0
2.00	Skilled Nursing Care	269	0	2,551	0	209,561	0
3.00	Physical Therapy	0	0	0	0	0	0
4.00	Occupational Therapy	0	0	0	0	0	0
5.00	Speech Pathology	0	0	0	0	0	0
6.00	Medical Social Services	0	0	0	0	0	0
7.00	Home Health Aide	0	0	0	0	0	0
8.00	Supplies (see instructions)	0	0	0	0	0	0
9.00	Drugs	0	0	0	0	0	0
10.00	DME	0	0	0	0	0	0
11.00	Home Dialysis Aide Services	0	0	0	0	0	0
12.00	Respiratory Therapy	0	0	0	0	0	0
13.00	Private Duty Nursing	0	0	0	0	0	0
14.00	Clinic	0	0	0	0	0	0
15.00	Health Promotion Activities	0	0	0	0	0	0
16.00	Day Care Program	0	0	0	0	0	0
17.00	Home Delivered Meals Program	0	0	0	0	0	0
18.00	Homemaker Service	0	0	0	0	0	0
19.00	All Others (specify)	0	0	0	0	0	0
19.50	Telemedicine	0	0	0	0	0	0
20.00	Total (sum of lines 1-19)	269	0	2,551	0	209,561	0
21.00	Total cost to be allocated	16,957	0	414	0	2,677	0
22.00	Unit cost multiplier	63.037175	0.000000	0.162289	0.000000	0.012774	0.000000

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1337

Period:

Worksheet H-3

HHA CCN: 14-7151

From 05/01/2020
To 04/30/2021Part I
Date/Time Prepared:
9/30/2021 1:25 pm

				Title XVIII		Home Health Agency I		
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	431,046		431,046	780	552.62	1.00
2.00	Physical Therapy	3.00	0	0	0	630	0.00	2.00
3.00	Occupational Therapy	4.00	0	0	0	104	0.00	3.00
4.00	Speech Pathology	5.00	0	0	0	0	0.00	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	0		0	0	0.00	6.00
7.00	Total (sum of lines 1-6)		431,046	0	431,046	1,514		7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits			
					Part B			
						Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		20994	0	4			8.00
8.01	Skilled Nursing Care		37900	0	32			8.01
8.02	Skilled Nursing Care		99914	0	449			8.02
9.00	Physical Therapy		20994	0	4			9.00
9.01	Physical Therapy		37900	0	28			9.01
9.02	Physical Therapy		99914	0	395			9.02
10.00	Occupational Therapy		20994	0	1			10.00
10.01	Occupational Therapy		37900	0	0			10.01
10.02	Occupational Therapy		99914	0	83			10.02
11.00	Speech Pathology		20994	0	0			11.00
11.01	Speech Pathology		37900	0	0			11.01
11.02	Speech Pathology		99914	0	0			11.02
12.00	Medical Social Services		20994	0	0			12.00
12.01	Medical Social Services		37900	0	0			12.01
12.02	Medical Social Services		99914	0	0			12.02
13.00	Home Health Aide		20994	0	0			13.00
13.01	Home Health Aide		37900	0	0			13.01
13.02	Home Health Aide		99914	0	11			13.02
14.00	Total (sum of lines 8-13)			0	1,007			14.00
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Cost Center Description		Program Visits			Cost of Services			
		Part A	Part B		Part A	Part B	Subject to Deductibles & Coinsurance	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance				
6.00	7.00	8.00	9.00	10.00	11.00			
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	485		0	268,021		1.00
2.00	Physical Therapy	0	427		0	0		2.00
3.00	Occupational Therapy	0	84		0	0		3.00
4.00	Speech Pathology	0	0		0	0		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	11		0	0		6.00
7.00	Total (sum of lines 1-6)	0	1,007		0	268,021		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1337

Period:

Worksheet H-3

HHA CCN: 14-7151

From 05/01/2020
To 04/30/2021Part I
Date/Time Prepared:
9/30/2021 1:25 pm

Title XVIII

Home Health
Agency I

Cost Center Description						Agency 1		
		6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00
Cost Center Description		Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			6.00	7.00	8.00	9.00	10.00	11.00
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	4,882	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of cols. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	268,021						1.00
2.00	Physical Therapy	0						2.00
3.00	Occupational Therapy	0						3.00
4.00	Speech Pathology	0						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	0						6.00
7.00	Total (sum of lines 1-6)	268,021						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1337

Period:

Worksheet H-3

HHA CCN: 14-7151

From 05/01/2020
To 04/30/2021Part II
Date/Time Prepared:
9/30/2021 1:25 pm

Title XVIII

Home Health
Agency I

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.402420	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy							2.00
3.00 Speech Pathology							3.00
4.00 Cost of Medical Supplies	71.00	0.000000	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.343479	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1337

Period:

Worksheet H-4

HHA CCN: 14-7151

From 05/01/2020
To 04/30/2021Part I-II
Date/Time Prepared:
9/30/2021 1:25 pm

Title XVIII

Home Health
Agency I

		Agency 1		Agency 2	
		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES					
Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00
			Part A Services	Part B Services	
			1.00	2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
10.00	Total reasonable cost (see instructions)		0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	126,477	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	16,778	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		0	2,861	13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	6,402	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	5,714	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	43	16.00
17.00	Total Other Payments		0	0	17.00
18.00	DME Payments		0	0	18.00
19.00	Oxygen Payments		0	0	19.00
20.00	Prosthetic and Orthotic Payments		0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	158,275	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		0	158,275	24.00
25.00	Coinsurance billed to program patients (from your records)		0	0	25.00
26.00	Net cost (line 24 minus line 25)		0	158,275	26.00
27.00	Reimbursable bad debts (from your records)				27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)				28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	158,275	29.00
30.00	OTHER ADJUSTMENTS		0	7,710	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	0	30.99
31.00	Subtotal (see instructions)		0	165,985	31.00
31.01	Sequestration adjustment (see instructions)		0	0	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	0	31.02
32.00	Interim payments (see instructions)		0	165,985	32.00
33.00	Tentative settlement (for contractor use only)		0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIESProvider CCN: 14-1337
HHA CCN: 14-7151Period:
From 05/01/2020
To 04/30/2021Worksheet H-5
Date/Time Prepared:
9/30/2021 1:25 pm

				Home Health Agency I	
		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		165,985
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
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
3.01			0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50			0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		165,985
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
5.01			0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50			0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		0		165,985
				Contractor Number	NPR Date (Mo/Day/Yr)
		0		1.00	2.00
8.00	Name of Contractor				

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1337

Period:

Worksheet M-1

Component CCN: 14-8549

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/30/2021 1:25 pm

		RHC I		Cost		
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,116,852	0	1,116,852	173,745	1,290,597
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	553,262	0	553,262	0	553,262
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	628,003	0	628,003	0	628,003
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	36,688	0	36,688	0	36,688
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	531,802	89,625	621,427	0	621,427
10.00	Subtotal (sum of lines 1 through 9)	2,866,607	89,625	2,956,232	173,745	3,129,977
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	27,549	27,549	0	27,549
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	27,549	27,549	0	27,549
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,866,607	117,174	2,983,781	173,745	3,157,526
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	103,638	103,638	0	103,638
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	121,357	0	121,357	0	121,357
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)	121,357	103,638	224,995	0	224,995
FACILITY OVERHEAD						
29.00	Facility Costs	0	23,982	23,982	0	23,982
30.00	Administrative Costs	0	226,409	226,409	0	226,409
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	250,391	250,391	0	250,391
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,987,964	471,203	3,459,167	173,745	3,632,912

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1337

Period:

Worksheet M-1

Component CCN: 14-8549

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/30/2021 1:25 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,290,597	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	553,262	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	628,003	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	36,688	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	-32,400	589,027	9.00
10.00	Subtotal (sum of lines 1 through 9)	-32,400	3,097,577	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	27,549	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	27,549	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-32,400	3,125,126	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	103,638	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	121,357	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	224,995	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	23,982	29.00
30.00	Administrative Costs	0	226,409	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	250,391	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-32,400	3,600,512	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1337

Period:

Worksheet M-1

Component CCN: 14-8583

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/30/2021 1:25 pm

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	40,613	0	40,613	17,514	58,127
2.00	Physician Assistant	31,963	0	31,963	0	31,963
3.00	Nurse Practitioner	179,832	0	179,832	0	179,832
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	16,600	0	16,600	0	16,600
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	286,096	0	286,096	0	286,096
10.00	Subtotal (sum of lines 1 through 9)	555,104	0	555,104	17,514	572,618
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	15,073	15,073	0	15,073
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	15,073	15,073	0	15,073
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	555,104	15,073	570,177	17,514	587,691
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	3,441	3,441	0	3,441
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	41,109	0	41,109	0	41,109
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)	41,109	3,441	44,550	0	44,550
FACILITY OVERHEAD						
29.00	Facility Costs	0	33,919	33,919	0	33,919
30.00	Administrative Costs	0	33,206	33,206	0	33,206
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	67,125	67,125	0	67,125
32.00	Total facility costs (sum of lines 22, 28 and 31)	596,213	85,639	681,852	17,514	699,366

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1337

Period:

Worksheet M-1

Component CCN: 14-8583

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/30/2021 1:25 pm

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	58,127	1.00
2.00	Physician Assistant	0	31,963	2.00
3.00	Nurse Practitioner	0	179,832	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	16,600	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	286,096	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	572,618	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	15,073	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	15,073	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	587,691	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	3,441	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	41,109	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	44,550	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	33,919	29.00
30.00	Administrative Costs	0	33,206	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	67,125	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	699,366	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1337

Period:

Worksheet M-2

Component CCN: 14-8549

From 05/01/2020

Date/Time Prepared:

To 04/30/2021

9/30/2021 1:25 pm

				RHC I		Cost	
		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	3.43	10,862	4,200	14,406		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	3.67	8,346	2,100	7,707		3.00
4.00	Subtotal (sum of lines 1 through 3)	7.10	19,208		22,113	22,113	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	0.17	737			737	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)	7.27	19,945			22,850	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)					3,125,126	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					224,995	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,350,121	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.932840	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					250,391	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,079,568	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,329,959	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,329,959	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,173,479	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					5,298,605	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1337

Period:

Worksheet M-2

Component CCN: 14-8583

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/30/2021 1:25 pm

				RHC II		Cost	
		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	0.20	256	4,200	840		1.00
2.00	Physician Assistant	0.29	580	2,100	609		2.00
3.00	Nurse Practitioner	1.58	3,174	2,100	3,318		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.07	4,010		4,767	4,767	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	0.38	651			651	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.45	4,661			5,418	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)					587,691	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					44,550	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					632,241	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.929536	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					67,125	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					487,653	15.00
16.00	Total overhead (sum of lines 14 and 15)					554,778	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					554,778	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					515,686	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,103,377	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1337 Component CCN: 14-8549	Period: From 05/01/2020 To 04/30/2021	Worksheet M-3 Date/Time Prepared: 9/30/2021 1:25 pm	
		Title XVIII	RHC I	Cost	
				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)			5,298,605	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			200,275	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			5,098,330	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			22,850	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)			22,850	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			223.12	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	223.12	223.12	223.12	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	6,591	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	1,470,584	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	4	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	892	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	892	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	1,471,476		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,199,869		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		91,759		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		112,530		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.)		979,560		16.04
16.05	Total program cost (see instructions)	0	1,092,090		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		134,496		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		194,723		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,092,090		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		100,611		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,192,701		22.00
23.00	Allowable bad debts (see instructions)		18,195		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		11,827		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		14,858		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)		1,204,528		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		1,242,363		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)		-37,835		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

Health Financial Systems		PERRY MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1337	Period: From 05/01/2020 To 04/30/2021	Worksheet M-3		
		Component CCN: 14-8583		Date/Time Prepared: 9/30/2021 1:25 pm		
		Title XVIII	RHC II	Cost		
			1.00			
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,103,377	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			10,649	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,092,728	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,418	4.00	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00	
6.00	Total adjusted visits (line 4 plus line 5)			5,418	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			201.68	7.00	
		Calculation of Limit (1)				
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)		
		1.00	2.00	3.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, \$20.6 or your contractor)		0.00	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		201.68	201.68	201.68	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		0	0	501	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	0	101,042	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	27	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	5,445	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	5,445	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	106,487		16.00
16.01	Total program charges (see instructions)(from contractor's records)			110,342		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			290		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			280		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.)			76,503		16.04
16.05	Total program cost (see instructions)		0	76,783		16.05
17.00	Primary payer amounts			0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			10,578		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			19,895		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			76,783		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			4,836		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			81,619		22.00
23.00	Allowable bad debts (see instructions)			1,111		23.00
23.01	Adjusted reimbursable bad debts (see instructions)			722		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			754		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)			82,341		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			63,623		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)			18,718		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 PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1337 Component CCN: 14-8549	Period: From 05/01/2020 To 04/30/2021	Worksheet M-4 Date/Time Prepared: 9/30/2021 1:25 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		3,097,577	3,097,577	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001421	0.004451	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		4,402	13,787	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		74,698	25,235	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		79,100	39,022	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		3,125,126	3,125,126	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,173,479	2,173,479	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.025311	0.012487	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		55,013	27,140	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		134,113	66,162	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		480	1,503	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		279.40	44.02	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		235	794	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		65,659	34,952	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			200,275	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			100,611	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1337 Component CCN: 14-8583	Period: From 05/01/2020 To 04/30/2021	Worksheet M-4 Date/Time Prepared: 9/30/2021 1:25 pm	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		572,618	572,618	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000134	0.002406	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		77	1,378	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		1,497	2,720	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		1,574	4,098	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		587,691	587,691	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		515,686	515,686	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.002678	0.006973	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		1,381	3,596	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		2,955	7,694	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		9	162	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		328.33	47.49	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		2	88	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		657	4,179	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			10,649	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			4,836	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1337 Component CCN: 14-8549	Period: From 05/01/2020 To 04/30/2021	Worksheet M-5 Date/Time Prepared: 9/30/2021 1:25 pm	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,256,649	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		12/29/2020	14,286	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)		-14,286	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,242,363	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		0	6.01	
6.02	SETTLEMENT TO PROGRAM		37,835	6.02	
7.00	Total Medicare program liability (see instructions)		1,204,528	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: 14-1337 Component CCN: 14-8583	Period: From 05/01/2020 To 04/30/2021	Worksheet M-5 Date/Time Prepared: 9/30/2021 1:25 pm	
		RHC II	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		62,371	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		12/29/2020	1,252	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)		1,252	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		63,623	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		18,718	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		82,341	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00