

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND PROVIDER CCN:14-1337		Period: From 05/01/2021 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/30/2021 2:08 pm
SETTLEMENT SUMMARY			

PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 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 THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE 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 OSF SAINT CLARE MEDICAL CENTER (14-1337) for the cost reporting period beginning 05/01/2021 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

☒ 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	282,449	324,970	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	6,535	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		14,662		0	10.00
10.01	RURAL HEALTH CLINIC II	0		24		0	10.01
200.00	Total	0	288,984	339,656	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 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 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.

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10						
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN:14-1337		Period: From 05/01/2021 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 2:08 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	OSF SAINT CLARE MEDICAL CENTER	141337	99914	1	07/15/2004	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	OSF SAINT CLARE MEDICAL CENTER	142337	99914		07/15/2004	N	O	N	7.00
8.00	Swing Beds - NF	OSF SAINT CLARE MEDICAL CENTER	142337	99914		07/15/2004	N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTG									11.00
12.00	Hospital-Based HHA	PERRY HOME CARE	147151	99914		05/01/2020	N	N	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	OSF HEALTHCARE - COMMUNITY HEALTH	148549	99914		11/04/2015	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC	OSF HEALTHCARE - PROMPT CARE	148583	99914		10/27/2017	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					05/01/2021	06/30/2021		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	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								22.04	
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/30/2021 2:08 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00
					Urban/Rural Status	Date of Geographic Reclassification	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					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)					With	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.					With	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. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					or "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.							57.00
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							58.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-1337		Period: From 05/01/2021 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 2:08 pm	
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" N for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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Period:
From 05/01/2021
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/30/2021 2:08 pm

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

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 2:08 pm	
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N			80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N			81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N			85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N			87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			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

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 2:08 pm	
			V	XIX	
			1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR N Section §412.113(c). Enter "Y" for yes or "N" for no.				108.00
			Physical	Occupational	Speech
			1.00	2.00	3.00
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	
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N		111.00
			1.00	2.00	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
<u>Miscellaneous Cost Reporting Information</u>					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00
			Premiums	Losses	Insurance
			1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:		29,694	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
<u>Transplant Center Information</u>					
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

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-1337		Period: From 05/01/2021 To 06/30/2021	
				Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 2:08 pm	
		1.00		2.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00	
133.00	Removed and reserved			133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00	
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			140.00	
		1.00		2.00	
		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:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
		1.00		2.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y	
		1.00		2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			146.00	
		1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N	
		Part A		Part B	
		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.			Enter N	
		Name		County	
		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	
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)				
168.01	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)				
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/30/2021 2:08 pm

		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)			0171.00

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 2:08 pm	
			Y/N 1.00	Date 2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	Y		07/01/2021	1.00
			Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	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 1.00	Legal Oper. 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 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 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.				13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		Part B
			Y/N 1.00	Date 2.00	Y/N 3.00
					Date 4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/09/2021	Y	11/09/2021
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	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN:14-1337		Period: From 05/01/2021 To 06/30/2021	
		Worksheet S-2 Part II		Date/Time Prepared: 11/30/2021 2:08 pm	
		Description		Y/N	
		0		1.00	
		Y/N		Date	
		1.00		2.00	
		Y/N		Date	
		1.00		2.00	
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	
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.			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 05/01/2021 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 2:08 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 05/01/2021
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 2:08 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	1,342	4,497.00	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	1,342	4,497.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	3	183	395.00	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	1,525	4,892.00	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 05/01/2021
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 2:08 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)	82	0	152			1.00
2.00 HMO and other (see instructions)	47	2				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	6	0	6			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	88	0	158			7.00
8.00 INTENSIVE CARE UNIT	24	1	32			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)	112	1	190	0.00	309.03	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	122	0	162	0.00	3.45	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	1,191	205	3,486	0.00	45.49	26.00
26.01 RURAL HEALTH CLINIC II	89	418	863	0.00	10.17	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	368.14	27.00
28.00 Observation Bed Days		0	144			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	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 05/01/2021
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 2:08 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	39	1	71	1.00
2.00 HMO and other (see instructions)			16	3		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	39	1	71	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

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER			In Lieu of Form CMS-2552-10		
HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN:14-1337 Component CCN:14-7151		Period: From 05/01/2021 To 06/30/2021	
				Worksheet S-4 Date/Time Prepared: 11/30/2021 2:08 pm			
				Home Health Agency I			
				1.00			
0.00 County				BUREAU		0.00	
				Title V	Title XVIII	Title XIX	Other
				1.00	2.00	3.00	4.00
				Total		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	10.00	0.00	0.00	10.00	2.00
		Number of Employees (Full Time Equivalent)					
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
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			0.52	0.00	0.52	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.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			37900			20.00
20.01				99914			20.01
		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	36	7	1	6	50	21.00
22.00	Skilled Nursing Visit Charges	6,280	1,200	200	1,000	8,680	22.00
23.00	Physical Therapy Visits	48	8	0	5	61	23.00
24.00	Physical Therapy Visit Charges	8,640	1,440	0	900	10,980	24.00
25.00	Occupational Therapy Visits	1	7	0	3	11	25.00
26.00	Occupational Therapy Visit Charges	140	980	0	420	1,540	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	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	85	22	1	14	122	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)	15,060	3,620	200	2,320	21,200	35.00
36.00	Total Number of Episodes (standard/non outlier)	7		1	0	8	36.00
37.00	Total Number of Outlier Episodes		1		1	2	37.00
38.00	Total Non-Routine Medical Supply Charges	478	15	15	151	659	38.00

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN:14-1337 Component CCN:14-8549		Period: From 05/01/2021 To 06/30/2021 Worksheet S-8 Date/Time Prepared: 11/30/2021 2:08 pm	
		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street	535 PARK AVENUE EAST			
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	PRINCETON		IL	61356
		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)				
5.00	Migrant Health Center (Section 329(d), PHS Act)				
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				
7.00	Appalachian Regional Commission				
8.00	Look-Alikes				
9.00	OTHER (SPECIFY)				
		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.)	yes or 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?	30.8? N		0	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.			0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				
		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)				
		County			
		4.00			
2.00	City, State, ZIP Code, County	BUREAU			
		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

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN:14-1337	Period: From 05/01/2021	Worksheet S-8
			Component CCN:14-8549	To 06/30/2021	Date/Time Prepared: 11/30/2021 2:08 pm
			RHC I		Cost
			Friday		Saturday
			from	to	from
			11.00	12.00	13.00
					14.00
Facility hours of operations (1)					
11.00	CLINIC	07:00	17:30		11.00

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN:14-1337 Component CCN:14-8583		Period: From 05/01/2021 To 06/30/2021 Worksheet S-8 Date/Time Prepared: 11/30/2021 2:08 pm	
		RHC II		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street	2128 N MAIN ST			
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	PRINCETON		IL	61356
				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)				
5.00	Migrant Health Center (Section 329(d), PHS Act)				
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				
7.00	Appalachian Regional Commission				
8.00	Look-Alikes				
9.00	OTHER (SPECIFY)				
		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.)	yes or 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	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.	30.8? N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				
		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)				
		County			
		4.00			
2.00	City, State, ZIP Code, County	BUREAU			
		Tuesday		Wednesday	Thursday
		to	from	to	from
		6.00	7.00	8.00	9.00
	Facility hours of operations (1)				
11.00	CLINIC	20:00	08:30	20:00	08:30
		20:00		20:00	

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN:14-1337	Period: From 05/01/2021	Worksheet S-8
			Component CCN:14-8583	To 06/30/2021	Date/Time Prepared: 11/30/2021 2:08 pm
			RHC II		Cost
			Friday		Saturday
			from	to	from
			11.00	12.00	13.00
					14.00
Facility hours of operations (1)					
11.00	CLINIC	08:30	20:00	08:30	14:00
					11.00

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/30/2021 2:08 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)			0.462993	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			815,589	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			1,929,480	6.00
7.00	Medicaid cost (line 1 times line 6)			893,336	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)			77,747	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			7,280	9.00
10.00	Stand-alone CHIP charges			29,988	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			13,884	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			6,604	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, 14, 16, 17, 18, and 19)			1284,351	19.00
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	23,451	40,599	64,050	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	10,858	40,599	51,457	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	10,858	40,599	51,457	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			353,911	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			52,448	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			80,688	27.01
28.00	Non-Medicare bad debt expense (see instructions)			273,223	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			154,740	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			206,197	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			290,548	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet A Date/Time Prepared: 11/30/2021 2:08 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		187,916	187,916	132,463	320,379	1.00
1.01	00101	PERRY PLAZA B&F		0	0	0	0	1.01
1.02	00102	PROMPT CARE		0	0	0	0	1.02
1.03	00103	WALNUT CLINIC		343	343	0	343	1.03
1.04	00104	HENRY CLINIC		739	739	0	739	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		275,039	275,039	19,501	294,540	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	53,138	-104,781	-51,643	-103,637	-155,280	4.00
5.01	00590	BUSINESS OFFICE	146,557	127,336	273,893	0	273,893	5.01
5.02	00591	A&G HOSPITAL-ONLY	87,479	833,352	920,831	-15,744	905,087	5.02
5.03	00592	A&G SHARED	207,419	1,504,974	1,712,393	-32,764	1,679,629	5.03
7.00	00700	OPERATION OF PLANT	127,757	233,334	361,091	0	361,091	7.00
7.01	00701	PERRY PLAZA PLANT OP	0	0	0	0	0	7.01
7.02	00702	PROMPT CARE PLANT OP	243	5,061	5,304	0	5,304	7.02
7.03	00703	WALNUT CLINIC PLANT OP	10	1,641	1,651	0	1,651	7.03
7.04	00704	HENRY CLINIC PLANT OP	67	1,500	1,567	0	1,567	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	15,744	15,744	8.00
9.00	00900	HOUSEKEEPING	69,256	27,226	96,482	0	96,482	9.00
9.01	00901	PERRY PLAZA HSKPING	0	0	0	0	0	9.01
9.02	00902	PROMPT CARE HSKPING	2,111	114	2,225	0	2,225	9.02
9.03	00903	WALNUT CLINIC HSKPING	0	0	0	0	0	9.03
9.04	00904	HENRY CLINIC HSKPING	0	0	0	0	0	9.04
10.00	01000	DIETARY	58,539	84,448	142,987	0	142,987	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	164,235	2,326	166,561	0	166,561	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,408	13,009	20,417	0	20,417	14.00
15.00	01500	PHARMACY	51,429	83,652	135,081	0	135,081	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	249,121	13,751	262,872	0	262,872	16.00
17.00	01700	SOCIAL SERVICE	98,416	1,166	99,582	0	99,582	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	210,706	49,272	259,978	3,395	263,373	30.00
31.00	03100	INTENSIVE CARE UNIT	100,638	40,756	141,394	0	141,394	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	286,239	248,320	534,559	-54,503	480,056	50.00
53.00	05300	ANESTHESIOLOGY	0	153,642	153,642	0	153,642	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	162,527	70,885	233,412	0	233,412	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	45,062	21,736	66,798	0	66,798	55.00
56.00	05600	RADIOISOTOPE	0	28,046	28,046	0	28,046	56.00
57.00	05700	CT SCAN	8,884	31,341	40,225	0	40,225	57.00
58.00	05800	MRI	20,457	18,312	38,769	0	38,769	58.00
60.00	06000	LABORATORY	182,302	211,212	393,514	0	393,514	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	13,853	13,853	0	13,853	63.00
65.00	06500	RESPIRATORY THERAPY	106,815	8,167	114,982	0	114,982	65.00
66.00	06600	PHYSICAL THERAPY	212,579	3,965	216,544	0	216,544	66.00
69.00	06900	ELECTROCARDIOLOGY	0	5,937	5,937	0	5,937	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	61	61	0	61	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	54,503	54,503	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	267,121	267,121	0	267,121	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	69,592	69,592	0	69,592	76.01
76.97	07697	CARDIAC REHABILITATION	17,118	1,356	18,474	0	18,474	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	636,090	161,789	797,879	44,414	842,293	88.00
88.01	08801	RURAL HEALTH CLINIC II	140,323	13,410	153,733	1,901	155,634	88.01
90.00	09000	CLINIC	418,850	4,971	423,821	39,219	463,040	90.00
90.01	04950	SLEEP LAB	12,804	1,646	14,450	0	14,450	90.01
90.02	09001	GENERAL SURGERY CL	80,665	23,369	104,034	10,999	115,033	90.02
90.03	09002	PM PAIN CLINIC	13,678	51,208	64,886	0	64,886	90.03
91.00	09100	EMERGENCY	250,778	487,049	737,827	-60	737,767	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	49,831	5,248	55,079	0	55,079	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		119,140	119,140	-119,140	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,279,531	5,403,550	9,683,081	-3,709	9,679,372	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	72,764	3,913	76,677	3,709	80,386	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	0	194.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021

Worksheet A

Date/Time Prepared:
11/30/2021 2:08 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	
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)	4,352,295	5,407,463	9,759,758	0	9,759,758	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES	Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet A Date/Time Prepared: 11/30/2021 2:08 pm
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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	-103,666	216,713	1.00
1.01	00101	PERRY PLAZA B&F	0	0	1.01
1.02	00102	PROMPT CARE	0	0	1.02
1.03	00103	WALNUT CLINIC	0	343	1.03
1.04	00104	HENRY CLINIC	0	739	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-188	294,352	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-88,170	-243,450	4.00
5.01	00590	BUSINESS OFFICE	0	273,893	5.01
5.02	00591	A&G HOSPITAL-ONLY	0	905,087	5.02
5.03	00592	A&G SHARED	-61,216	1,618,413	5.03
7.00	00700	OPERATION OF PLANT	-1,576	359,515	7.00
7.01	00701	PERRY PLAZA PLANT OP	0	0	7.01
7.02	00702	PROMPT CARE PLANT OP	0	5,304	7.02
7.03	00703	WALNUT CLINIC PLANT OP	0	1,651	7.03
7.04	00704	HENRY CLINIC PLANT OP	0	1,567	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	-496	15,248	8.00
9.00	00900	HOUSEKEEPING	0	96,482	9.00
9.01	00901	PERRY PLAZA HSKPING	0	0	9.01
9.02	00902	PROMPT CARE HSKPING	0	2,225	9.02
9.03	00903	WALNUT CLINIC HSKPING	0	0	9.03
9.04	00904	HENRY CLINIC HSKPING	0	0	9.04
10.00	01000	DIETARY	-13,093	129,894	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	-2,674	163,887	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	20,417	14.00
15.00	01500	PHARMACY	0	135,081	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-301	262,571	16.00
17.00	01700	SOCIAL SERVICE	0	99,582	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-72,044	191,329	30.00
31.00	03100	INTENSIVE CARE UNIT	0	141,394	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	480,056	50.00
53.00	05300	ANESTHESIOLOGY	-149,787	3,855	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	233,412	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-3,836	62,962	55.00
56.00	05600	RADIOISOTOPE	0	28,046	56.00
57.00	05700	CT SCAN	0	40,225	57.00
58.00	05800	MRI	0	38,769	58.00
60.00	06000	LABORATORY	-6,210	387,304	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	13,853	63.00
65.00	06500	RESPIRATORY THERAPY	0	114,982	65.00
66.00	06600	PHYSICAL THERAPY	0	216,544	66.00
69.00	06900	ELECTROCARDIOLOGY	-5,680	257	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	61	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	54,503	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-3,848	263,273	73.00
76.00	03140	CARDIOLOGY	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	69,592	76.01
76.97	07697	CARDIAC REHABILITATION	0	18,474	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-5,400	836,893	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	155,634	88.01
90.00	09000	CLINIC	-443,434	19,606	90.00
90.01	04950	SLEEP LAB	0	14,450	90.01
90.02	09001	GENERAL SURGERY CL	-118,368	-3,335	90.02
90.03	09002	PM PAIN CLINIC	-45,454	19,432	90.03
91.00	09100	EMERGENCY	-354,377	383,390	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	55,079	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,479,818	8,199,554	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	80,386	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 05/01/2021 To 06/30/2021	Worksheet A Date/Time Prepared: 11/30/2021 2:08 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)	-1,479,818	8,279,940		200.00

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - INTEREST					1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	119,140		
	TOTALS		0	119,140		
1.00 2.00 3.00 5.00 6.00	B - PROPERTY INSURANCE					1.00 2.00 3.00 5.00 6.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	13,323		
	CAP REL COSTS-MVBLE EQUIP	2.00	0	19,501		
		0.00	0	0		
		0.00	0	0		
		0.00	0	0		
	TOTALS		0	32,824		
	C - EMPLOYEE PHYSICALS					
1.00	A&G SHARED	5.03	0	60	1.00	
	TOTALS		0	60		
1.00	D - CONTRACT LAUNDRY					1.00
	LAUNDRY & LINEN SERVICE	8.00	0	15,744		
	TOTALS		0	15,744		
1.00	E - IMPLANTS					1.00
	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	54,503		
	TOTALS		0	54,503		
1.00 2.00 3.00 4.00 5.00 6.00	F - PHYSICIAN BENEFITS					1.00 2.00 3.00 4.00 5.00 6.00
	ADULTS & PEDIATRICS	30.00	0	3,395		
	RURAL HEALTH CLINIC	88.00	0	44,414		
	CLINIC	90.00	0	39,219		
	GENERAL SURGERY CL	90.02	0	10,999		
	WALNUT & HENRY CLINICS	194.00	0	3,709		
	RURAL HEALTH CLINIC II	88.01	0	1,901		
	TOTALS		0	103,637		
500.00	Grand Total: Increases		0	325,908	500.00	

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
1.00	A - INTEREST						1.00
	INTEREST EXPENSE	113.00	0	119,140	11		
	TOTALS		0	119,140			
	B - PROPERTY INSURANCE						
1.00	A&G SHARED	5.03	0	32,824	12		1.00
2.00		0.00	0	0	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	32,824			
	C - EMPLOYEE PHYSICALS						
1.00	EMERGENCY	91.00	0	60	0		1.00
	TOTALS		0	60			
	D - CONTRACT LAUNDRY						
1.00	A&G HOSPITAL-ONLY	5.02	0	15,744	0		1.00
	TOTALS		0	15,744			
	E - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	54,503	0		1.00
	TOTALS		0	54,503			
	F - PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	103,637	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	103,637			
500.00	Grand Total: Decreases		0	325,908			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/30/2021 2:08 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	681,222	0	0	0	0	1.00
2.00	Land Improvements	1,320,801	0	0	0	0	2.00
3.00	Buildings and Fixtures	41,442,357	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	21,501,884	0	0	0	0	6.00
7.00	HIT designated Assets	185,458	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	65,131,722	0	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	65,131,722	0	0	0	0	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 05/01/2021
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/30/2021 2:08 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	187,916	0	0	0	0	1.00
1.01	PERRY PLAZA B&F	0	0	0	0	0	1.01
1.02	PROMPT CARE	0	0	0	0	0	1.02
1.03	WALNUT CLINIC	343	0	0	0	0	1.03
1.04	HENRY CLINIC	739	0	0	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	275,039	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	464,037	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	187,916				1.00
1.01	PERRY PLAZA B&F	0	0				1.01
1.02	PROMPT CARE	0	0				1.02
1.03	WALNUT CLINIC	0	343				1.03
1.04	HENRY CLINIC	0	739				1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	275,039				2.00
3.00	Total (sum of lines 1-2)	0	464,037				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/30/2021 2:08 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	188,267	0	1.00
1.01	PERRY PLAZA B&F	0	0	0	0	0	1.01
1.02	PROMPT CARE	0	0	0	0	0	1.02
1.03	WALNUT CLINIC	0	0	0	343	0	1.03
1.04	HENRY CLINIC	0	0	0	739	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	274,851	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	464,200	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	15,123	13,323	0	0	216,713	1.00
1.01	PERRY PLAZA B&F	0	0	0	0	0	1.01
1.02	PROMPT CARE	0	0	0	0	0	1.02
1.03	WALNUT CLINIC	0	0	0	0	343	1.03
1.04	HENRY CLINIC	0	0	0	0	739	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	19,501	0	0	294,352	2.00
3.00	Total (sum of lines 1-2)	15,123	32,824	0	0	512,147	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/30/2021 2:08 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.	
				Cost Center				
1.00				3.00		4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-11,879	CAP REL COSTS-BLDG & FIXT		1.00	11	1.00
1.01	Investment income - PERRY PLAZA B&F (chapter 2)			PERRY PLAZA B&F		1.01	0	1.01
1.02	Investment income - PROMPT CARE (chapter 2)			PROMPT CARE		1.02	0	1.02
1.03	Investment income - WALNUT CLINIC (chapter 2)			WALNUT CLINIC		1.03	0	1.03
1.04	Investment income - HENRY CLINIC (chapter 2)			HENRY CLINIC		1.04	0	1.04
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			CAP REL COSTS-MVBLE EQUIP		2.00	0	2.00
3.00	Investment income - other (chapter 2)		0			0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		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	-1,199,190				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	-496	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 employees 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	-329	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		RESPIRATORY THERAPY		65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY		66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***		114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			CAP REL COSTS-BLDG & FIXT		1.00	0	26.00
26.01	Depreciation - PERRY PLAZA B&F			PERRY PLAZA B&F		1.01	0	26.01
26.02	Depreciation - PROMPT CARE			PROMPT CARE		1.02	0	26.02
26.03	Depreciation - WALNUT CLINIC			WALNUT CLINIC		1.03	0	26.03
26.04	Depreciation - HENRY CLINIC			HENRY CLINIC		1.04	0	26.04
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			CAP REL COSTS-MVBLE EQUIP		2.00	0	27.00
28.00	Non-physician Anesthetist			*** Cost Center Deleted ***		19.00		28.00

ADJUSTMENTS TO EXPENSES

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/30/2021 2:08 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
29.00	Physicians' assistant	0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	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)	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	-188	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	CAFETERIA	-7,960	DIETARY	10.00	0	33.00
33.01	DIETICIAN REVENUE	-776	DIETARY	10.00	0	33.01
33.02	OUTSIDE CATERING	-1,109	DIETARY	10.00	0	33.02
33.03	MEDICAL RECORDS	-301	MEDICAL RECORDS & LIBRARY	16.00	0	33.03
33.04	CONTRACT NURSING	-2,674	NURSING ADMINISTRATION	13.00	0	33.04
33.05	MISCELLANEOUS		A&G SHARED	5.03	0	33.05
33.06	MOBILE MEALS	-2,919	DIETARY	10.00	0	33.06
33.07	GASB 68		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	TELEPHONE EXPENSE	-1,576	OPERATION OF PLANT	7.00	0	33.08
33.09	340B EXPENSE OFFSET	-3,848	DRUGS CHARGED TO PATIENTS	73.00	0	33.09
33.11	MEDICAL DIRECTOR TO A SNF	-5,400	RURAL HEALTH CLINIC	88.00	0	33.11
33.12	AMORTIZATION EXPENSE	-92,138	CAP REL COSTS-BLDG & FIXT	1.00	11	33.12
33.13	TELEPHONE SALARY OFFSET		A&G HOSPITAL-ONLY	5.02	0	33.13
33.14	TELEPHONE BENEFIT OFFSET		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	NON-ALLOWABLE MARKETING	-58,700	A&G SHARED	5.03	0	33.15
33.16	MARKETING BENEFITS	2,409	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.16
33.17	RENTAL PROPERTY - CAPITAL	351	CAP REL COSTS-BLDG & FIXT	1.00	9	33.17
33.18	2004 BOND INTEREST		CAP REL COSTS-BLDG & FIXT	1.00	11	33.18
33.21	IHA DUES OFFSET	-2,516	A&G SHARED	5.03	0	33.21
33.22	ALCOHOL EXP		A&G SHARED	5.03	0	33.22
33.23	PHYSICIAN ON CALL		A&G SHARED	5.03	0	33.23
33.24	SELF-INSURANCE OFFSET	-90,579	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.24
33.25	UNFUNDED OTHER POST EMPLOYMENT BENEF		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.25
33.26	SOCIAL ORG. DUES - PRINCETON ROTARY		A&G SHARED	5.03	0	33.26
33.27	NON-ALLOWABLE NOTE INTEREST		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.)	-1,479,818				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 05/01/2021
To 06/30/2021

Worksheet A-8-2

Date/Time Prepared:
11/30/2021 2:08 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	431,807	354,377	77,430	0	0	1.00
2.00	90.00	CLINIC	98	98	0	0	0	2.00
3.00	90.00	CLINIC	443,336	443,336	0	0	0	3.00
4.00	90.02	GENERAL SURGERY CL	95,568	95,568	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	6,210	6,210	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	149,787	149,787	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	5.03	A&G SHARED	1,500	0	1,500	0	0	9.00
10.00	30.00	ADULTS & PEDIATRICS	30,819	30,819	0	0	0	10.00
11.00	30.00	ADULTS & PEDIATRICS	41,225	41,225	0	0	0	11.00
12.00	90.03	PM PAIN CLINIC	45,454	45,454	0	0	0	12.00
13.00	69.00	ELECTROCARDIOLOGY	5,680	5,680	0	0	0	13.00
14.00	55.00	RADIOLOGY-THERAPEUTIC	3,836	3,836	0	0	0	14.00
16.00	10.00	DIETARY	0	0	0	0	0	16.00
17.00	90.02	GENERAL SURGERY CL	22,800	22,800	0	0	0	17.00
200.00			1,278,120	1,199,190	78,930			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	354,377		1.00
2.00	90.00	CLINIC	0	0	0	98		2.00
3.00	90.00	CLINIC	0	0	0	443,336		3.00
4.00	90.02	GENERAL SURGERY CL	0	0	0	95,568		4.00
5.00	50.00	OPERATING ROOM	0	0	0	0		5.00
6.00	60.00	LABORATORY	0	0	0	6,210		6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	149,787		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	30,819		10.00
11.00	30.00	ADULTS & PEDIATRICS	0	0	0	41,225		11.00
12.00	90.03	PM PAIN CLINIC	0	0	0	45,454		12.00
13.00	69.00	ELECTROCARDIOLOGY	0	0	0	5,680		13.00
14.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	3,836		14.00
16.00	10.00	DIETARY	0	0	0	0		16.00
17.00	90.02	GENERAL SURGERY CL	0	0	0	22,800		17.00
200.00			0	0	0	1,199,190		200.00

MCRIF32 - 16.12.172.7

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN:14-1337		Period: From 05/01/2021 To 06/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/30/2021 2:08 pm	
		Speech Pathology		Cost			
		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)						0 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)						0 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 05/01/2021
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/30/2021 2:08 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	216,713	216,713				1.00
1.01	00101	PERRY PLAZA B&F	0	0	0			1.01
1.02	00102	PROMPT CARE	0	0	0	0		1.02
1.03	00103	WALNUT CLINIC	343	0	0	0	343	1.03
1.04	00104	HENRY CLINIC	739	0	0	0	0	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	294,352					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-243,450	749	0	0	0	4.00
5.01	00590	BUSINESS OFFICE	273,893	3,914	0	0	0	5.01
5.02	00591	A&G HOSPITAL-ONLY	905,087	7,822	0	0	0	5.02
5.03	00592	A&G SHARED	1,618,413	15,235	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	359,515	60,971	0	0	0	7.00
7.01	00701	PERRY PLAZA PLANT OP	0	0	0	0	0	7.01
7.02	00702	PROMPT CARE PLANT OP	5,304	0	0	0	0	7.02
7.03	00703	WALNUT CLINIC PLANT OP	1,651	0	0	0	46	7.03
7.04	00704	HENRY CLINIC PLANT OP	1,567	0	0	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	15,248	801	0	0	0	8.00
9.00	00900	HOUSEKEEPING	96,482	1,666	0	0	0	9.00
9.01	00901	PERRY PLAZA HSKPING	0	0	0	0	0	9.01
9.02	00902	PROMPT CARE HSKPING	2,225	0	0	0	0	9.02
9.03	00903	WALNUT CLINIC HSKPING	0	0	0	0	6	9.03
9.04	00904	HENRY CLINIC HSKPING	0	0	0	0	0	9.04
10.00	01000	DIETARY	129,894	5,019	0	0	0	10.00
11.00	01100	CAFETERIA	0	2,495	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	163,887	1,801	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,417	1,790	0	0	0	14.00
15.00	01500	PHARMACY	135,081	1,903	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	262,571	4,070	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	99,582	607	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	191,329	19,754	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	141,394	3,470	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	480,056	22,900	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	3,855	174	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	233,412	3,603	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	62,962	333	0	0	0	55.00
56.00	05600	RADIOISOTOPE	28,046	858	0	0	0	56.00
57.00	05700	CT SCAN	40,225	975	0	0	0	57.00
58.00	05800	MRI	38,769	1,120	0	0	0	58.00
60.00	06000	LABORATORY	387,304	3,907	0	0	45	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	13,853	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	114,982	2,015	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	216,544	5,188	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	257	74	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	61	337	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	54,503	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	263,273	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	69,592	1,505	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	18,474	1,020	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	836,893	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	155,634	0	0	0	0	88.01
90.00	09000	CLINIC	19,606	6,307	0	0	0	90.00
90.01	04950	SLEEP LAB	14,450	677	0	0	0	90.01
90.02	09001	GENERAL SURGERY CL	-3,335	2,867	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	19,432	1,335	0	0	0	90.03
91.00	09100	EMERGENCY	383,390	8,721	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	55,079	668	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)	8,199,554	196,651	0	0	97	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	644	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	477	0	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/30/2021 2:08 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	
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	80,386	0	0	0	246	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	2,302	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	16,639	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	201.00
202.00		TOTAL (sum lines 118 through 201)	8,279,940	216,713	0	0	343	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/30/2021 2:08 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	739					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		294,352				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	-242,701			4.00
5.01	00590	BUSINESS OFFICE	0	0	0	277,807		5.01
5.02	00591	A&G HOSPITAL-ONLY	0	159,758	0	0	1,072,667	5.02
5.03	00592	A&G SHARED	0	1,192	0	0	1,634,840	5.03
7.00	00700	OPERATION OF PLANT	0	112	0	0	420,598	7.00
7.01	00701	PERRY PLAZA PLANT OP	0	0	0	0	0	7.01
7.02	00702	PROMPT CARE PLANT OP	0	0	0	0	5,304	7.02
7.03	00703	WALNUT CLINIC PLANT OP	0	0	0	0	1,697	7.03
7.04	00704	HENRY CLINIC PLANT OP	192	0	0	0	1,759	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	16,049	8.00
9.00	00900	HOUSEKEEPING	0	88	0	0	98,236	9.00
9.01	00901	PERRY PLAZA HSKPING	0	0	0	0	0	9.01
9.02	00902	PROMPT CARE HSKPING	0	0	0	0	2,225	9.02
9.03	00903	WALNUT CLINIC HSKPING	0	0	0	0	6	9.03
9.04	00904	HENRY CLINIC HSKPING	29	0	0	0	29	9.04
10.00	01000	DIETARY	0	2,009	0	0	136,922	10.00
11.00	01100	CAFETERIA	0	0	0	0	2,495	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	165,688	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	905	0	0	23,112	14.00
15.00	01500	PHARMACY	0	147	0	0	137,131	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	636	0	0	267,277	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	100,189	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	6,187	0	11,593	228,863	30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,353	0	1,488	151,705	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	28,020	0	41,167	572,143	50.00
53.00	05300	ANESTHESIOLOGY	0	10,868	0	3,285	18,182	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	50,957	0	10,178	298,150	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	86	0	7,993	71,374	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,402	31,306	56.00
57.00	05700	CT SCAN	0	170	0	31,058	72,428	57.00
58.00	05800	MRI	0	496	0	7,689	48,074	58.00
60.00	06000	LABORATORY	163	7,955	0	59,147	458,521	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	925	14,778	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,904	0	3,249	122,150	65.00
66.00	06600	PHYSICAL THERAPY	0	1,067	0	10,183	232,982	66.00
69.00	06900	ELECTROCARDIOLOGY	0	859	0	2,685	3,875	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	44	442	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	3,875	58,378	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	24,803	288,076	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	0	1,928	73,025	76.01
76.97	07697	CARDIAC REHABILITATION	0	945	0	1,143	21,582	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	3,710	0	11,146	851,749	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	206	0	2,983	158,823	88.01
90.00	09000	CLINIC	0	1,982	0	2,381	30,276	90.00
90.01	04950	SLEEP LAB	0	233	0	1,501	16,861	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	1,041	573	90.02
90.03	09002	PM PAIN CLINIC	0	1,318	0	879	22,964	90.03
91.00	09100	EMERGENCY	0	6,739	0	32,843	431,693	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	0	198	55,945	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	384	293,902	0	277,807	8,421,142	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	644	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	477	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	355	450	0	0	81,437	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1337

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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	BUSINESS OFFICE	Subtotal	
			HENRY CLINIC	MVBLE EQUIP				
			1.04	2.00	4.00	5.01	5A.01	
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	2,302	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	16,639	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					0	200.00
201.00		Negative Cost Centers	0	0	-242,701	0	-242,701	201.00
202.00		TOTAL (sum lines 118 through 201)	739	294,352	-242,701	277,807	8,279,940	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1337

Period:
From 05/01/2021
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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	1,072,667					5.02
5.03	00592	A&G SHARED	235,387	1,870,227	1,870,227			5.03
7.00	00700	OPERATION OF PLANT	60,559	481,157	135,270	616,427		7.00
7.01	00701	PERRY PLAZA PLANT OP	0	0	0	0	0	7.01
7.02	00702	PROMPT CARE PLANT OP	764	6,068	1,706	0	0	7.02
7.03	00703	WALNUT CLINIC PLANT OP	244	1,941	546	0	0	7.03
7.04	00704	HENRY CLINIC PLANT OP	253	2,012	566	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	2,311	18,360	5,162	3,859	0	8.00
9.00	00900	HOUSEKEEPING	14,144	112,380	31,594	8,020	0	9.00
9.01	00901	PERRY PLAZA HSKPING	0	0	0	0	0	9.01
9.02	00902	PROMPT CARE HSKPING	320	2,545	715	0	0	9.02
9.03	00903	WALNUT CLINIC HSKPING	1	7	2	0	0	9.03
9.04	00904	HENRY CLINIC HSKPING	4	33	9	0	0	9.04
10.00	01000	DIETARY	19,714	156,636	44,036	24,166	0	10.00
11.00	01100	CAFETERIA	359	2,854	802	12,013	0	11.00
13.00	01300	NURSING ADMINISTRATION	23,856	189,544	53,287	8,670	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,328	26,440	7,433	8,619	0	14.00
15.00	01500	PHARMACY	19,745	156,876	44,103	9,163	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	38,483	305,760	85,960	19,596	0	16.00
17.00	01700	SOCIAL SERVICE	14,426	114,615	32,222	2,923	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	32,952	261,815	73,605	95,115	0	30.00
31.00	03100	INTENSIVE CARE UNIT	21,843	173,548	48,790	16,707	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	82,379	654,522	184,009	110,265	0	50.00
53.00	05300	ANESTHESIOLOGY	2,618	20,800	5,848	840	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,929	341,079	95,889	17,351	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	10,277	81,651	22,955	1,602	0	55.00
56.00	05600	RADIOISOTOPE	4,508	35,814	10,069	4,133	0	56.00
57.00	05700	CT SCAN	10,428	82,856	23,294	4,693	0	57.00
58.00	05800	MRI	6,922	54,996	15,461	5,393	0	58.00
60.00	06000	LABORATORY	66,019	524,540	147,467	18,812	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,128	16,906	4,753	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	17,588	139,738	39,285	9,700	0	65.00
66.00	06600	PHYSICAL THERAPY	33,545	266,527	74,930	24,979	0	66.00
69.00	06900	ELECTROCARDIOLOGY	558	4,433	1,246	358	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	64	506	142	1,624	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	8,405	66,783	18,775	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,478	329,554	92,649	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	10,514	83,539	23,486	7,247	0	76.01
76.97	07697	CARDIAC REHABILITATION	3,107	24,689	6,941	4,912	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	122,637	974,386	273,938	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	22,868	181,691	51,080	0	0	88.01
90.00	09000	CLINIC	4,359	34,635	9,737	30,366	0	90.00
90.01	04950	SLEEP LAB	2,428	19,289	5,423	3,260	0	90.01
90.02	09001	GENERAL SURGERY CL	83	656	184	13,805	0	90.02
90.03	09002	PM PAIN CLINIC	3,306	26,270	7,385	6,429	0	90.03
91.00	09100	EMERGENCY	62,156	493,849	138,838	41,993	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	8,055	64,000	17,993	3,215	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,058,052	8,406,527	1,837,585	519,828	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	93	737	207	3,103	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	69	546	153	2,296	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	11,726	93,163	26,191	0	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	331	2,633	740	11,084	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	2,396	19,035	5,351	80,116	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

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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	0	0	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	-242,701	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,072,667	8,279,940	1,870,227	616,427	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
From 05/01/2021
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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	7,774					7.02
7.03	00703	WALNUT CLINIC PLANT OP	0	2,487				7.03
7.04	00704	HENRY CLINIC PLANT OP	0	0	2,578			7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	27,381		8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	151,994	9.00
9.01	00901	PERRY PLAZA HSKPING	0	0	0	0	0	9.01
9.02	00902	PROMPT CARE HSKPING	342	0	0	0	0	9.02
9.03	00903	WALNUT CLINIC HSKPING	0	53	0	0	0	9.03
9.04	00904	HENRY CLINIC HSKPING	0	0	138	0	0	9.04
10.00	01000	DIETARY	0	0	0	0	2,332	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	3,499	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	318	3,499	14.00
15.00	01500	PHARMACY	0	0	0	0	1,555	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	777	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	1,944	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	5,354	27,989	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	965	2,721	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	8,316	32,654	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,063	0	0	1,292	7,775	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	1,027	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	163	0	56.00
57.00	05700	CT SCAN	0	0	0	1,020	1,555	57.00
58.00	05800	MRI	0	0	0	731	777	58.00
60.00	06000	LABORATORY	491	377	769	0	5,442	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	2,332	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	897	3,499	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	3,887	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	1,166	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	90	25,656	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,878	0	0	18	777	88.01
90.00	09000	CLINIC	0	0	0	68	0	90.00
90.01	04950	SLEEP LAB	0	0	0	0	1,944	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	62	0	90.02
90.03	09002	PM PAIN CLINIC	0	0	0	0	3,110	90.03
91.00	09100	EMERGENCY	0	0	0	6,445	12,828	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	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,774	430	907	26,766	147,718	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	2,057	1,671	615	4,276	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
194.03	07953	MOB LEASED SPACE	0	0	0	0	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

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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)	7,774	2,487	2,578	27,381	151,994	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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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	0					9.01
9.02	00902	PROMPT CARE HSKPING	0	3,602				9.02
9.03	00903	WALNUT CLINIC HSKPING	0	0	62			9.03
9.04	00904	HENRY CLINIC HSKPING	0	0	0	180		9.04
10.00	01000	DIETARY	0	0	0	0	227,170	10.00
11.00	01100	CAFETERIA	0	0	0	0	164,586	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	46	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	232	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	32,612	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	17,742	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	5,374	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	515	0	0	417	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	93	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	238	10	57	139	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	46	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	1,112	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,849	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	46	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	4,725	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,602	10	57	227,170	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	0	52	123	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
194.03	07953	MOB LEASED SPACE	0	0	0	0	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

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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	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)	0	3,602	62	180	227,170	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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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	00500	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	180,255					11.00
13.00	01300	NURSING ADMINISTRATION	7,130	262,176				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,086	6,306	54,701			14.00
15.00	01500	PHARMACY	4,421		987	217,105		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,626				428,719	16.00
17.00	01700	SOCIAL SERVICE	6,850					17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,011	72,195	2,012		17,891	30.00
31.00	03100	INTENSIVE CARE UNIT	4,826	29,430	381		2,296	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	24,143	75,743	22,351		63,534	50.00
53.00	05300	ANESTHESIOLOGY			814		5,070	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,469		106		15,708	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,219		798		12,336	55.00
56.00	05600	RADIOISOTOPE			71		3,707	56.00
57.00	05700	CT SCAN	1,136		2,154		47,931	57.00
58.00	05800	MRI	2,288		378		11,867	58.00
60.00	06000	LABORATORY	14,540		3,969		91,256	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.					1,428	63.00
65.00	06500	RESPIRATORY THERAPY	4,764		225		5,015	65.00
66.00	06600	PHYSICAL THERAPY	17,327		662		15,716	66.00
69.00	06900	ELECTROCARDIOLOGY			59		4,144	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY					68	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT						71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			12,563		5,980	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				217,105	38,279	73.00
76.00	03140	CARDIOLOGY						76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS					2,976	76.01
76.97	07697	CARDIAC REHABILITATION	2,102		53		1,764	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC			747		17,202	88.00
88.01	08801	RURAL HEALTH CLINIC II			538		4,603	88.01
90.00	09000	CLINIC	10,306		380		3,675	90.00
90.01	04950	SLEEP LAB	436		277		2,316	90.01
90.02	09001	GENERAL SURGERY CL	4,795		90		1,607	90.02
90.03	09002	PM PAIN CLINIC	2,211				1,357	90.03
91.00	09100	EMERGENCY	12,672	78,502	4,810		50,687	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	4,203		10		306	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	173,561	262,176	54,435	217,105	428,719	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES						192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY						192.03
194.00	07956	WALNUT & HENRY CLINICS	6,694		266			194.00
194.01	07951	HOSPITAL LEASED SPACE						194.01
194.02	07950	PERRY HOME CARE - HHA						194.02

COST ALLOCATION - GENERAL SERVICE COSTS

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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)	180,255	262,176	54,701	217,105	428,719	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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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	00500	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	158,786				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	136,001	738,600	0	738,600	30.00
31.00	03100	INTENSIVE CARE UNIT	22,785	320,191	0	320,191	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,180,911	0	1,180,911	50.00
53.00	05300	ANESTHESIOLOGY	0	33,372	0	33,372	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	493,664	0	493,664	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	124,588	0	124,588	55.00
56.00	05600	RADIOISOTOPE	0	54,050	0	54,050	56.00
57.00	05700	CT SCAN	0	164,639	0	164,639	57.00
58.00	05800	MRI	0	91,891	0	91,891	58.00
60.00	06000	LABORATORY	0	808,107	0	808,107	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	23,087	0	23,087	63.00
65.00	06500	RESPIRATORY THERAPY	0	201,059	0	201,059	65.00
66.00	06600	PHYSICAL THERAPY	0	404,537	0	404,537	66.00
69.00	06900	ELECTROCARDIOLOGY	0	10,240	0	10,240	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,340	0	2,340	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	104,101	0	104,101	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	677,587	0	677,587	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	121,181	0	121,181	76.01
76.97	07697	CARDIAC REHABILITATION	0	41,627	0	41,627	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,293,131	0	1,293,131	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	247,434	0	247,434	88.01
90.00	09000	CLINIC	0	89,167	0	89,167	90.00
90.01	04950	SLEEP LAB	0	32,991	0	32,991	90.01
90.02	09001	GENERAL SURGERY CL	0	21,199	0	21,199	90.02
90.03	09002	PM PAIN CLINIC	0	46,762	0	46,762	90.03
91.00	09100	EMERGENCY	0	845,349	0	845,349	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	89,727	0	89,727	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	158,786	8,261,532	0	8,261,532	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,047	0	4,047	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,995	0	2,995	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	135,108	0	135,108	194.00

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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		
194.01	07951	HOSPITAL LEASED SPACE	0	14,457	0	14,457		194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0		194.02
194.03	07953	MOB LEASED SPACE	0	104,502	0	104,502		194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0	0		194.05
194.06	07954	PM PROMPT CARE	0	0	0	0		194.06
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	-242,701	0	-242,701		201.00
202.00		TOTAL (sum lines 118 through 201)	158,786	8,279,940	0	8,279,940		202.00

ALLOCATION OF CAPITAL RELATED COSTS

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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	
				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	749	0	0	4.00	
5.01	00590	BUSINESS OFFICE	0	3,914	0	0	5.01	
5.02	00591	A&G HOSPITAL-ONLY	0	7,822	0	0	5.02	
5.03	00592	A&G SHARED	0	15,235	0	0	5.03	
7.00	00700	OPERATION OF PLANT	0	60,971	0	0	7.00	
7.01	00701	PERRY PLAZA PLANT OP	0	0	0	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	46	7.03	
7.04	00704	HENRY CLINIC PLANT OP	0	0	0	0	7.04	
8.00	00800	LAUNDRY & LINEN SERVICE	0	801	0	0	8.00	
9.00	00900	HOUSEKEEPING	0	1,666	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	6	9.03	
9.04	00904	HENRY CLINIC HSKPING	0	0	0	0	9.04	
10.00	01000	DIETARY	0	5,019	0	0	10.00	
11.00	01100	CAFETERIA	0	2,495	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	0	1,801	0	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,790	0	0	14.00	
15.00	01500	PHARMACY	0	1,903	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,070	0	0	16.00	
17.00	01700	SOCIAL SERVICE	0	607	0	0	17.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	19,754	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	3,470	0	0	31.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	22,900	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0	174	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,603	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	333	0	0	55.00	
56.00	05600	RADIOISOTOPE	0	858	0	0	56.00	
57.00	05700	CT SCAN	0	975	0	0	57.00	
58.00	05800	MRI	0	1,120	0	0	58.00	
60.00	06000	LABORATORY	0	3,907	0	45	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00	
65.00	06500	RESPIRATORY THERAPY	0	2,015	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	5,188	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	74	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	337	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	1,505	0	0	76.01	
76.97	07697	CARDIAC REHABILITATION	0	1,020	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	0	0	0	88.01	
90.00	09000	CLINIC	0	6,307	0	0	90.00	
90.01	04950	SLEEP LAB	0	677	0	0	90.01	
90.02	09001	GENERAL SURGERY CL	0	2,867	0	0	90.02	
90.03	09002	PM PAIN CLINIC	0	1,335	0	0	90.03	
91.00	09100	EMERGENCY	0	8,721	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00	
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	668	0	0	101.00	
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	196,651	0	0	97118.00	
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	644	0	0	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	477	0	0	192.00	
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	192.03	

ALLOCATION OF CAPITAL RELATED COSTS

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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	
				1.00	1.01	1.02	1.03	
194.00	07956	WALNUT & HENRY CLINICS	0	0	0	0	246	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	2,302	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	16,639	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	201.00
202.00		TOTAL (sum lines 118 through 201)	0	216,713	0	0	343	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	BUSINESS OFFICE	
			HENRY CLINIC	MVBLE EQUIP				
			1.04	2.00				
			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	749	749		4.00
5.01	00590	BUSINESS OFFICE	0	0	3,914	0	3,914	5.01
5.02	00591	A&G HOSPITAL-ONLY	0	159,758	167,580	0	0	5.02
5.03	00592	A&G SHARED	0	1,192	16,427	0	0	5.03
7.00	00700	OPERATION OF PLANT	0	112	61,083	0	0	7.00
7.01	00701	PERRY PLAZA PLANT OP	0	0	0	0	0	7.01
7.02	00702	PROMPT CARE PLANT OP	0	0	0	0	0	7.02
7.03	00703	WALNUT CLINIC PLANT OP	0	0	46	0	0	7.03
7.04	00704	HENRY CLINIC PLANT OP	192	0	192	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	801	0	0	8.00
9.00	00900	HOUSEKEEPING	0	88	1,754	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	0	0	0	9.02
9.03	00903	WALNUT CLINIC HSKPING	0	0	6	0	0	9.03
9.04	00904	HENRY CLINIC HSKPING	29	0	29	0	0	9.04
10.00	01000	DIETARY	0	2,009	7,028	0	0	10.00
11.00	01100	CAFETERIA	0	0	2,495	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,801	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	905	2,695	0	0	14.00
15.00	01500	PHARMACY	0	147	2,050	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	636	4,706	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	607	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	6,187	25,941	0	163	30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,353	8,823	0	21	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	28,020	50,920	0	580	50.00
53.00	05300	ANESTHESIOLOGY	0	10,868	11,042	0	46	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	50,957	54,560	0	143	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	86	419	0	113	55.00
56.00	05600	RADIOISOTOPE	0	0	858	0	34	56.00
57.00	05700	CT SCAN	0	170	1,145	0	438	57.00
58.00	05800	MRI	0	496	1,616	0	108	58.00
60.00	06000	LABORATORY	163	7,955	12,070	0	831	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	13	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,904	3,919	0	46	65.00
66.00	06600	PHYSICAL THERAPY	0	1,067	6,255	0	144	66.00
69.00	06900	ELECTROCARDIOLOGY	0	859	933	0	38	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	337	0	1	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	55	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	350	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	1,505	0	27	76.01
76.97	07697	CARDIAC REHABILITATION	0	945	1,965	0	16	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	3,710	3,710	0	157	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	206	206	0	42	88.01
90.00	09000	CLINIC	0	1,982	8,289	0	34	90.00
90.01	04950	SLEEP LAB	0	233	910	0	21	90.01
90.02	09001	GENERAL SURGERY CL	0	0	2,867	0	15	90.02
90.03	09002	PM PAIN CLINIC	0	1,318	2,653	0	12	90.03
91.00	09100	EMERGENCY	0	6,739	15,460	0	463	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	668	0	3	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	384	293,902	491,034	0	3,914	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	644	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	477	0	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	355	450	1,051	0	0	194.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021Worksheet B
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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	
194.01	07951	HOSPITAL LEASED SPACE	0	0	2,302	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	16,639	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			0			200.00
201.00		Negative Cost Centers	0	0	0	749	0	201.00
202.00		TOTAL (sum lines 118 through 201)	739	294,352	512,147	749	3,914	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1337

Period:
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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	167,580					5.02
5.03	00592	A&G SHARED	36,774	53,201				5.03
7.00	00700	OPERATION OF PLANT	9,461	3,848	74,392			7.00
7.01	00701	PERRY PLAZA PLANT OP	0	0	0	0		7.01
7.02	00702	PROMPT CARE PLANT OP	119	49	0	0	168	7.02
7.03	00703	WALNUT CLINIC PLANT OP	38	16	0	0	0	7.03
7.04	00704	HENRY CLINIC PLANT OP	40	16	0	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	361	147	466	0	0	8.00
9.00	00900	HOUSEKEEPING	2,210	899	968	0	0	9.00
9.01	00901	PERRY PLAZA HSKPING	0	0	0	0	0	9.01
9.02	00902	PROMPT CARE HSKPING	50	20	0	0	7	9.02
9.03	00903	WALNUT CLINIC HSKPING	0	0	0	0	0	9.03
9.04	00904	HENRY CLINIC HSKPING	1	0	0	0	0	9.04
10.00	01000	DIETARY	3,080	1,253	2,916	0	0	10.00
11.00	01100	CAFETERIA	56	23	1,450	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,727	1,516	1,046	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	520	211	1,040	0	0	14.00
15.00	01500	PHARMACY	3,085	1,255	1,106	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,012	2,445	2,365	0	0	16.00
17.00	01700	SOCIAL SERVICE	2,254	917	353	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,148	2,094	11,479	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,412	1,388	2,016	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,870	5,234	13,307	0	0	50.00
53.00	05300	ANESTHESIOLOGY	409	166	101	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,707	2,728	2,094	0	23	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,605	653	193	0	0	55.00
56.00	05600	RADIOISOTOPE	704	286	499	0	0	56.00
57.00	05700	CT SCAN	1,629	663	566	0	0	57.00
58.00	05800	MRI	1,081	440	651	0	0	58.00
60.00	06000	LABORATORY	10,314	4,195	2,270	0	11	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	332	135	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,748	1,117	1,171	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,241	2,131	3,014	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	87	35	43	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10	4	196	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	1,313	534	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,480	2,635	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	1,643	668	875	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	485	197	593	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	19,159	7,795	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,573	1,453	0	0	127	88.01
90.00	09000	CLINIC	681	277	3,665	0	0	90.00
90.01	04950	SLEEP LAB	379	154	393	0	0	90.01
90.02	09001	GENERAL SURGERY CL	13	5	1,666	0	0	90.02
90.03	09002	PM PAIN CLINIC	517	210	776	0	0	90.03
91.00	09100	EMERGENCY	9,711	3,949	5,068	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,258	512	388	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	165,297	52,273	62,734	0	168	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14	6	374	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11	4	277	0	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	1,832	745	0	0	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	52	21	1,338	0	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	374	152	9,669	0	0	194.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1337

Period:
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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	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)	167,580	53,201	74,392	0	168	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1337

Period:
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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	100				7.03
7.04	00704	HENRY CLINIC PLANT OP	0	248			7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,775		8.00
9.00	00900	HOUSEKEEPING	0	0	0	5,831	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	2	0	0	0	9.03
9.04	00904	HENRY CLINIC HSKPING	0	13	0	0	9.04
10.00	01000	DIETARY	0	0	0	89	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	134	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	21	134	14.00
15.00	01500	PHARMACY	0	0	0	60	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	30	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	75	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	347	1,074	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	63	104	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	538	1,253	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	84	298	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	67	0	55.00
56.00	05600	RADIOISOTOPE	0	0	11	0	56.00
57.00	05700	CT SCAN	0	0	66	60	57.00
58.00	05800	MRI	0	0	47	30	58.00
60.00	06000	LABORATORY	15	74	0	209	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	89	65.00
66.00	06600	PHYSICAL THERAPY	0	0	58	134	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	149	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	45	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	6	984	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	1	30	88.01
90.00	09000	CLINIC	0	0	4	0	90.00
90.01	04950	SLEEP LAB	0	0	0	75	90.01
90.02	09001	GENERAL SURGERY CL	0	0	4	0	90.02
90.03	09002	PM PAIN CLINIC	0	0	0	119	90.03
91.00	09100	EMERGENCY	0	0	418	492	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)	17	87	1,735	5,667	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	83	161	40	164	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

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Cost Center Description			WALNUT CLINIC PLANT OP	HENRY CLINIC PLANT OP	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	PERRY PLAZA HSPKING	
			7.03	7.04	8.00	9.00	9.01	
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)	100	248	1,775	5,831	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1337

Period:
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To 06/30/2021Worksheet B
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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	77				9.02
9.03	00903	WALNUT CLINIC HSKPING	0	8			9.03
9.04	00904	HENRY CLINIC HSKPING	0	0	43		9.04
10.00	01000	DIETARY	0	0	0	14,366	10.00
11.00	01100	CAFETERIA	0	0	0	10,408	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	3	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	15	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	2,062	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	1,122	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	340	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11	0	0	26	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	5	1	14	9	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	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	70	88.00
88.01	08801	RURAL HEALTH CLINIC II	61	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	04950	SLEEP LAB	0	0	0	3	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	299	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)	77	1	14	14,366	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	7	29	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 05/01/2021
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 2:08 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)	77	8	43	14,366	14,432	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 2:08 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	8,798					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	212	5,000				14.00
15.00	01500	PHARMACY	0	90	8,000			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	16,889		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	4,769	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,423	184	0	705	4,085	30.00
31.00	03100	INTENSIVE CARE UNIT	988	35	0	90	684	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,542	2,043	0	2,504	0	50.00
53.00	05300	ANESTHESIOLOGY	0	74	0	200	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10	0	619	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	73	0	486	0	55.00
56.00	05600	RADIOISOTOPE	0	7	0	146	0	56.00
57.00	05700	CT SCAN	0	197	0	1,889	0	57.00
58.00	05800	MRI	0	35	0	468	0	58.00
60.00	06000	LABORATORY	0	363	0	3,593	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	56	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	21	0	198	0	65.00
66.00	06600	PHYSICAL THERAPY	0	60	0	619	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	5	0	163	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3	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	1,148	0	236	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	8,000	1,508	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	0	117	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	5	0	69	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	68	0	678	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	49	0	181	0	88.01
90.00	09000	CLINIC	0	35	0	145	0	90.00
90.01	04950	SLEEP LAB	0	25	0	91	0	90.01
90.02	09001	GENERAL SURGERY CL	0	8	0	63	0	90.02
90.03	09002	PM PAIN CLINIC	0	0	0	53	0	90.03
91.00	09100	EMERGENCY	2,633	440	0	1,997	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	1	0	12	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,798	4,976	8,000	16,889	4,769	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	24	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 05/01/2021
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 2:08 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)	8,798	5,000	8,000	16,889	4,769	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 2:08 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	00500	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	56,827	0	56,827	30.00
31.00	03100	INTENSIVE CARE UNIT	19,132	0	19,132	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	94,065	0	94,065	50.00
53.00	05300	ANESTHESIOLOGY	12,038	0	12,038	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	68,301	0	68,301	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,947	0	3,947	55.00
56.00	05600	RADIOISOTOPE	2,551	0	2,551	56.00
57.00	05700	CT SCAN	6,744	0	6,744	57.00
58.00	05800	MRI	4,659	0	4,659	58.00
60.00	06000	LABORATORY	35,138	0	35,138	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	536	0	536	63.00
65.00	06500	RESPIRATORY THERAPY	9,690	0	9,690	65.00
66.00	06600	PHYSICAL THERAPY	19,043	0	19,043	66.00
69.00	06900	ELECTROCARDIOLOGY	1,304	0	1,304	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	551	0	551	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,286	0	3,286	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,973	0	18,973	73.00
76.00	03140	CARDIOLOGY	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	4,987	0	4,987	76.01
76.97	07697	CARDIAC REHABILITATION	3,543	0	3,543	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	32,627	0	32,627	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,723	0	5,723	88.01
90.00	09000	CLINIC	13,955	0	13,955	90.00
90.01	04950	SLEEP LAB	2,086	0	2,086	90.01
90.02	09001	GENERAL SURGERY CL	5,025	0	5,025	90.02
90.03	09002	PM PAIN CLINIC	4,517	0	4,517	90.03
91.00	09100	EMERGENCY	41,945	0	41,945	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,179	0	3,179	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	474,372	0	474,372	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,038	0	1,038	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	769	0	769	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	4,672	0	4,672	194.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/30/2021 2:08 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
194.01	07951	HOSPITAL LEASED SPACE	3,713	0	3,713		194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0		194.02
194.03	07953	MOB LEASED SPACE	26,834	0	26,834		194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0		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	749	0	749		201.00
202.00		TOTAL (sum lines 118 through 201)	512,147	0	512,147		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 2:08 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	186,315					1.00
1.01	00101	PERRY PLAZA B&F	0	0				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	644	0	0	0	0	4.00
5.01	00590	BUSINESS OFFICE	3,365	0	0	0	0	5.01
5.02	00591	A&G HOSPITAL-ONLY	6,725	0	0	0	0	5.02
5.03	00592	A&G SHARED	13,098	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	52,418	0	0	0	0	7.00
7.01	00701	PERRY PLAZA PLANT OP	0	0	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	689	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,432	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	4,315	0	0	0	0	10.00
11.00	01100	CAFETERIA	2,145	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,548	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,539	0	0	0	0	14.00
15.00	01500	PHARMACY	1,636	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,499	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	522	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	16,983	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,983	0	0	0	0	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	19,688	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	150	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,098	0	249	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	286	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	738	0	0	0	0	56.00
57.00	05700	CT SCAN	838	0	0	0	0	57.00
58.00	05800	MRI	963	0	0	0	0	58.00
60.00	06000	LABORATORY	3,359	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	1,732	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,460	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	64	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	290	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	877	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	1,377	0	0	88.01
90.00	09000	CLINIC	5,422	0	0	0	0	90.00
90.01	04950	SLEEP LAB	582	0	0	0	0	90.01
90.02	09001	GENERAL SURGERY CL	2,465	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	1,148	0	0	0	0	90.03
91.00	09100	EMERGENCY	7,498	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	574	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)	169,067	0	2,185	231	1,597	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	554	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	410	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 05/01/2021
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 2:08 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	1,979	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	14,305	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)	216,713	0	0	343	739	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.163154	0.000000	0.000000	0.420859	0.240795	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 05/01/2021
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 2:08 pm

Cost Center Description			CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	BUSINESS OFFICE (GROSS REVENUE)	Reconciliation	A&G HOSPITAL-ONLY (ACCUM. COST)	
			MVBLE EQUIP (DOLLAR VALUE)					
			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						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	274,851					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,533,557				4.00
5.01	00590	BUSINESS OFFICE	0	146,557	19,575,609			5.01
5.02	00591	A&G HOSPITAL-ONLY	149,174	61,302	0	-1,072,667	7,449,974	5.02
5.03	00592	A&G SHARED	1,113	207,419	0	0	1,634,840	5.03
7.00	00700	OPERATION OF PLANT	105	127,757	0	0	420,598	7.00
7.01	00701	PERRY PLAZA PLANT OP	0	0	0	0	0	7.01
7.02	00702	PROMPT CARE PLANT OP	0	243	0	0	5,304	7.02
7.03	00703	WALNUT CLINIC PLANT OP	0	10	0	0	1,697	7.03
7.04	00704	HENRY CLINIC PLANT OP	0	67	0	0	1,759	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	16,049	8.00
9.00	00900	HOUSEKEEPING	82	69,256	0	0	98,236	9.00
9.01	00901	PERRY PLAZA HSKPING	0	0	0	0	0	9.01
9.02	00902	PROMPT CARE HSKPING	0	2,111	0	0	2,225	9.02
9.03	00903	WALNUT CLINIC HSKPING	0	0	0	0	6	9.03
9.04	00904	HENRY CLINIC HSKPING	0	0	0	0	29	9.04
10.00	01000	DIETARY	1,876	58,539	0	0	136,922	10.00
11.00	01100	CAFETERIA	0	0	0	0	2,495	11.00
13.00	01300	NURSING ADMINISTRATION	0	164,235	0	0	165,688	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	845	7,408	0	0	23,112	14.00
15.00	01500	PHARMACY	137	51,429	0	0	137,131	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	594	249,121	0	0	267,277	16.00
17.00	01700	SOCIAL SERVICE	0	98,416	0	0	100,189	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,777	172,876	816,920	0	228,863	30.00
31.00	03100	INTENSIVE CARE UNIT	4,998	100,638	104,856	0	151,705	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,164	286,239	2,900,946	0	572,143	50.00
53.00	05300	ANESTHESIOLOGY	10,148	0	231,500	0	18,182	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,581	162,527	717,241	0	298,150	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	80	45,062	563,253	0	71,374	55.00
56.00	05600	RADIOISOTOPE	0	0	169,259	0	31,306	56.00
57.00	05700	CT SCAN	159	8,884	2,188,538	0	72,428	57.00
58.00	05800	MRI	463	20,457	541,837	0	48,074	58.00
60.00	06000	LABORATORY	7,428	182,302	4,167,064	0	458,521	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	65,202	0	14,778	63.00
65.00	06500	RESPIRATORY THERAPY	1,778	106,815	228,970	0	122,150	65.00
66.00	06600	PHYSICAL THERAPY	996	212,579	717,570	0	232,982	66.00
69.00	06900	ELECTROCARDIOLOGY	802	0	189,234	0	3,875	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	3,114	0	442	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	273,055	0	58,378	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,747,810	0	288,076	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	135,874	0	73,025	76.01
76.97	07697	CARDIAC REHABILITATION	882	17,118	80,525	0	21,582	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,464	425,229	785,447	0	851,749	88.00
88.01	08801	RURAL HEALTH CLINIC II	192	135,298	210,172	0	158,823	88.01
90.00	09000	CLINIC	1,851	37,133	167,801	0	30,276	90.00
90.01	04950	SLEEP LAB	218	12,804	105,768	0	16,861	90.01
90.02	09001	GENERAL SURGERY CL	0	0	73,360	0	573	90.02
90.03	09002	PM PAIN CLINIC	1,231	13,678	61,960	0	22,964	90.03
91.00	09100	EMERGENCY	6,293	250,778	2,314,383	0	431,693	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	49,831	13,950	0	55,945	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	274,431	3,484,118	19,575,609	-1,072,667	7,348,475	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	644	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	477	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 2:08 pm

Cost Center Description			CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	BUSINESS OFFICE (GROSS REVENUE)	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	420	49,439	0	0	81,437	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	2,302	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	16,639	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)	294,352	-242,701	277,807		1,072,667	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.070951	0.000000	0.014191		0.143983	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		749	3,914		167,580	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000212	0.000200		0.022494	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 05/01/2021
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 2:08 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	-1,870,227	6,652,414			5.03
7.00	00700	OPERATION OF PLANT	0	481,157	110,065		7.00
7.01	00701	PERRY PLAZA PLANT OP	0	0	0	0	7.01
7.02	00702	PROMPT CARE PLANT OP	0	6,068	0	1,821	7.02
7.03	00703	WALNUT CLINIC PLANT OP	0	1,941	0	0	7.03
7.04	00704	HENRY CLINIC PLANT OP	0	2,012	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,360	689	0	8.00
9.00	00900	HOUSEKEEPING	0	112,380	1,432	0	9.00
9.01	00901	PERRY PLAZA HSKPING	0	0	0	0	9.01
9.02	00902	PROMPT CARE HSKPING	0	2,545	0	80	9.02
9.03	00903	WALNUT CLINIC HSKPING	0	7	0	0	9.03
9.04	00904	HENRY CLINIC HSKPING	0	33	0	0	9.04
10.00	01000	DIETARY	0	156,636	4,315	0	10.00
11.00	01100	CAFETERIA	0	2,854	2,145	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	189,544	1,548	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	26,440	1,539	0	14.00
15.00	01500	PHARMACY	0	156,876	1,636	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	305,760	3,499	0	16.00
17.00	01700	SOCIAL SERVICE	0	114,615	522	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	261,815	16,983	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	173,548	2,983	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	654,522	19,688	0	50.00
53.00	05300	ANESTHESIOLOGY	0	20,800	150	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	341,079	3,098	249	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	81,651	286	0	55.00
56.00	05600	RADIOISOTOPE	0	35,814	738	0	56.00
57.00	05700	CT SCAN	0	82,856	838	0	57.00
58.00	05800	MRI	0	54,996	963	0	58.00
60.00	06000	LABORATORY	0	524,540	3,359	115	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	16,906	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	139,738	1,732	0	65.00
66.00	06600	PHYSICAL THERAPY	0	266,527	4,460	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	4,433	64	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	506	290	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	66,783	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	329,554	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	83,539	1,294	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	24,689	877	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	974,386	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	181,691	0	1,377	88.01
90.00	09000	CLINIC	0	34,635	5,422	0	90.00
90.01	04950	SLEEP LAB	0	19,289	582	0	90.01
90.02	09001	GENERAL SURGERY CL	0	656	2,465	0	90.02
90.03	09002	PM PAIN CLINIC	0	26,270	1,148	0	90.03
91.00	09100	EMERGENCY	0	493,849	7,498	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	64,000	574	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,870,227	6,536,300	92,817	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	737	554	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	546	410	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	93,163	0	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	2,633	1,979	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 2:08 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	19,035	14,305	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)		1,870,227	616,427	0	7,774	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.281135	5.600572	0.000000	4.269083	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		53,201	74,392	0	168	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.007997	0.675892	0.000000	0.092257	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

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To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 2:08 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	22,891		8.00
9.00	00900	HOUSEKEEPING	0	0	0	391	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	15	0	0	0	9.03
9.04	00904	HENRY CLINIC HSKPING	0	122	0	0	9.04
10.00	01000	DIETARY	0	0	0	6	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	9	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	266	9	14.00
15.00	01500	PHARMACY	0	0	0	4	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	2	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	5	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	4,476	72	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	807	7	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	6,952	84	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,080	20	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	859	0	55.00
56.00	05600	RADIOISOTOPE	0	0	136	0	56.00
57.00	05700	CT SCAN	0	0	853	4	57.00
58.00	05800	MRI	0	0	611	2	58.00
60.00	06000	LABORATORY	107	678	0	14	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6	65.00
66.00	06600	PHYSICAL THERAPY	0	0	750	9	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	10	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	3	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	75	66	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	15	2	88.01
90.00	09000	CLINIC	0	0	57	0	90.00
90.01	04950	SLEEP LAB	0	0	0	5	90.01
90.02	09001	GENERAL SURGERY CL	0	0	52	0	90.02
90.03	09002	PM PAIN CLINIC	0	0	0	8	90.03
91.00	09100	EMERGENCY	0	0	5,388	33	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)	122	800	22,377	380	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	584	1,472	514	11	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 2:08 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	
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)	2,487	2,578	27,381	151,994	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.522663	1.134683	1.196147	388.731458	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	100	248	1,775	5,831	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.141643	0.109155	0.077541	14.913043	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 2:08 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	4,904	10.00
11.00	01100	CAFETERIA	0	0	0	3,553	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1	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	5	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	704	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	383	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	116	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	249	0	0	9	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2	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	115	107	678	3	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	1	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	24	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,377	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	04950	SLEEP LAB	0	0	0	1	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	102	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)	1,741	107	678	4,904	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	584	1,472	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 2:08 pm

Cost Center Description			PROMPT CARE HSKPING (PROMPT CARE SQ FT)	9.02	WALNUT CLINIC HSKPING (WALNUT CLINIC SQ FT)	9.03	HENRY CLINIC HSKPING (HENRY CLINIC SQ FT)	9.04	DIETARY (MEALS SERVED)	10.00	CAFETERIA (FTE'S SERV ED)	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)		3,602		62		180		227,170		180,255	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		2.068926		0.089725		0.083721		46.323409		15.567407	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		77		8		43		14,366		14,432	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.044227		0.011577		0.020000		2.929445		1.246394	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 05/01/2021
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 2:08 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	00500	BUSINESS OFFICE					5.01
5.02	00501	A&G HOSPITAL-ONLY					5.02
5.03	00502	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	3,991				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	96	237,313			14.00
15.00	01500	PHARMACY	0	4,283	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	19,575,609	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	223 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,099	8,730	0	816,920	191 30.00
31.00	03100	INTENSIVE CARE UNIT	448	1,651	0	104,856	32 31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,153	96,963	0	2,900,946	0 50.00
53.00	05300	ANESTHESIOLOGY	0	3,531	0	231,500	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	461	0	717,241	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,463	0	563,253	0 55.00
56.00	05600	RADIOISOTOPE	0	309	0	169,259	0 56.00
57.00	05700	CT SCAN	0	9,344	0	2,188,538	0 57.00
58.00	05800	MRI	0	1,640	0	541,837	0 58.00
60.00	06000	LABORATORY	0	17,220	0	4,167,064	0 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	65,202	0 63.00
65.00	06500	RESPIRATORY THERAPY	0	977	0	228,970	0 65.00
66.00	06600	PHYSICAL THERAPY	0	2,871	0	717,570	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	257	0	189,234	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,114	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	54,503	0	273,055	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	1,747,810	0 73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0 76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	0	135,874	0 76.01
76.97	07697	CARDIAC REHABILITATION	0	229	0	80,525	0 76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,241	0	785,447	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,333	0	210,172	0 88.01
90.00	09000	CLINIC	0	1,649	0	167,801	0 90.00
90.01	04950	SLEEP LAB	0	1,201	0	105,768	0 90.01
90.02	09001	GENERAL SURGERY CL	0	389	0	73,360	0 90.02
90.03	09002	PM PAIN CLINIC	0	0	0	61,960	0 90.03
91.00	09100	EMERGENCY	1,195	20,868	0	2,314,383	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	44	0	13,950	0 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,991	236,157	100	19,575,609	223 118.00
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	1,156	0	0	0 194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 2:08 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)	262,176	54,701	217,105	428,719	158,786	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	65.691807	0.230501	2,171.050000	0.021901	712.044843	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,798	5,000	8,000	16,889	4,769	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.204460	0.021069	80.000000	0.000863	21.385650	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 05/01/2021
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 2:08 pm

			Title XVIII	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	738,600		738,600	0
31.00	03100	INTENSIVE CARE UNIT	320,191		320,191	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,180,911		1,180,911	0
53.00	05300	ANESTHESIOLOGY	33,372		33,372	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	493,664		493,664	0
55.00	05500	RADIOLOGY-THERAPEUTIC	124,588		124,588	0
56.00	05600	RADIOISOTOPE	54,050		54,050	0
57.00	05700	CT SCAN	164,639		164,639	0
58.00	05800	MRI	91,891		91,891	0
60.00	06000	LABORATORY	808,107		808,107	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	23,087		23,087	0
65.00	06500	RESPIRATORY THERAPY	201,059	0	201,059	0
66.00	06600	PHYSICAL THERAPY	404,537	0	404,537	0
69.00	06900	ELECTROCARDIOLOGY	10,240		10,240	0
70.00	07000	ELECTROENCEPHALOGRAPHY	2,340		2,340	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	104,101		104,101	0
73.00	07300	DRUGS CHARGED TO PATIENTS	677,587		677,587	0
76.00	03140	CARDIOLOGY	0		0	0
76.01	03950	SENIOR BEHAVIORAL WELLNESS	121,181		121,181	0
76.97	07697	CARDIAC REHABILITATION	41,627		41,627	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,293,131		1,293,131	0
88.01	08801	RURAL HEALTH CLINIC II	247,434		247,434	0
90.00	09000	CLINIC	89,167		89,167	0
90.01	04950	SLEEP LAB	32,991		32,991	0
90.02	09001	GENERAL SURGERY CL	21,199		21,199	0
90.03	09002	PM PAIN CLINIC	46,762		46,762	0
91.00	09100	EMERGENCY	845,349		845,349	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	352,181		352,181	0
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	89,727		89,727	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	8,613,713	0	8,613,713	0
201.00		Less Observation Beds	352,181		352,181	0
202.00		Total (see instructions)	8,261,532	0	8,261,532	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 2:08 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	396,036		396,036		30.00
31.00	03100	INTENSIVE CARE UNIT	104,863		104,863		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	389,428	2,459,997	2,849,425	0.414438	0.000000
53.00	05300	ANESTHESIOLOGY	25,294	190,294	215,588	0.154795	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,139	675,358	704,497	0.700733	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	10,734	547,447	558,181	0.223204	0.000000
56.00	05600	RADIOISOTOPE	5,362	157,089	162,451	0.332716	0.000000
57.00	05700	CT SCAN	33,031	2,142,834	2,175,865	0.075666	0.000000
58.00	05800	MRI	8,857	515,818	524,675	0.175139	0.000000
60.00	06000	LABORATORY	150,000	2,902,906	3,052,906	0.264701	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	14,597	50,605	65,202	0.354084	0.000000
65.00	06500	RESPIRATORY THERAPY	124,349	101,782	226,131	0.889126	0.000000
66.00	06600	PHYSICAL THERAPY	41,826	663,294	705,120	0.573714	0.000000
69.00	06900	ELECTROCARDIOLOGY	4,072	181,348	185,420	0.055226	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,114	3,114	0.751445	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	125,363	149,409	274,772	0.378863	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	128,108	1,622,398	1,750,506	0.387081	0.000000
76.00	03140	CARDIOLOGY	0	0	0	0.000000	0.000000
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	135,874	135,874	0.891863	0.000000
76.97	07697	CARDIAC REHABILITATION	5,000	74,345	79,345	0.524633	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,408	770,251	771,659		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	206,570	206,570		88.01
90.00	09000	CLINIC	2,500	91,690	94,190	0.946672	0.000000
90.01	04950	SLEEP LAB	3,000	102,768	105,768	0.311919	0.000000
90.02	09001	GENERAL SURGERY CL	0	23,615	23,615	0.897692	0.000000
90.03	09002	PM PAIN CLINIC	0	20,437	20,437	2.288105	0.000000
91.00	09100	EMERGENCY	18,201	2,157,019	2,175,220	0.388627	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,187	261,184	262,371	1.342302	0.000000
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	13,950	13,950		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	1,622,355	16,221,396	17,843,751		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	1,622,355	16,221,396	17,843,751		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 2:08 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 05/01/2021 To 06/30/2021		Worksheet C Part I Date/Time Prepared: 11/30/2021 2:08 pm	
			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	738,600		738,600	0	738,600	30.00
31.00	03100	INTENSIVE CARE UNIT	320,191		320,191	0	320,191	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,180,911		1,180,911	0	1,180,911	50.00
53.00	05300	ANESTHESIOLOGY	33,372		33,372	0	33,372	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	493,664		493,664	0	493,664	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	124,588		124,588	0	124,588	55.00
56.00	05600	RADIOISOTOPE	54,050		54,050	0	54,050	56.00
57.00	05700	CT SCAN	164,639		164,639	0	164,639	57.00
58.00	05800	MRI	91,891		91,891	0	91,891	58.00
60.00	06000	LABORATORY	808,107		808,107	0	808,107	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	23,087		23,087	0	23,087	63.00
65.00	06500	RESPIRATORY THERAPY	201,059	0	201,059	0	201,059	65.00
66.00	06600	PHYSICAL THERAPY	404,537	0	404,537	0	404,537	66.00
69.00	06900	ELECTROCARDIOLOGY	10,240		10,240	0	10,240	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,340		2,340	0	2,340	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	104,101		104,101	0	104,101	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	677,587		677,587	0	677,587	73.00
76.00	03140	CARDIOLOGY	0		0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	121,181		121,181	0	121,181	76.01
76.97	07697	CARDIAC REHABILITATION	41,627		41,627	0	41,627	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,293,131		1,293,131	0	1,293,131	88.00
88.01	08801	RURAL HEALTH CLINIC II	247,434		247,434	0	247,434	88.01
90.00	09000	CLINIC	89,167		89,167	0	89,167	90.00
90.01	04950	SLEEP LAB	32,991		32,991	0	32,991	90.01
90.02	09001	GENERAL SURGERY CL	21,199		21,199	0	21,199	90.02
90.03	09002	PM PAIN CLINIC	46,762		46,762	0	46,762	90.03
91.00	09100	EMERGENCY	845,349		845,349	0	845,349	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	352,181		352,181		352,181	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	89,727		89,727		89,727	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	8,613,713	0	8,613,713	0	8,613,713	200.00
201.00		Less Observation Beds	352,181		352,181		352,181	201.00
202.00		Total (see instructions)	8,261,532	0	8,261,532	0	8,261,532	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 2:08 pm

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	396,036		396,036		30.00
31.00	03100	INTENSIVE CARE UNIT	104,863		104,863		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	389,428	2,459,997	2,849,425	0.414438	50.00
53.00	05300	ANESTHESIOLOGY	25,294	190,294	215,588	0.154795	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,139	675,358	704,497	0.700733	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	10,734	547,447	558,181	0.223204	55.00
56.00	05600	RADIOISOTOPE	5,362	157,089	162,451	0.332716	56.00
57.00	05700	CT SCAN	33,031	2,142,834	2,175,865	0.075666	57.00
58.00	05800	MRI	8,857	515,818	524,675	0.175139	58.00
60.00	06000	LABORATORY	150,000	2,902,906	3,052,906	0.264701	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	14,597	50,605	65,202	0.354084	63.00
65.00	06500	RESPIRATORY THERAPY	124,349	101,782	226,131	0.889126	65.00
66.00	06600	PHYSICAL THERAPY	41,826	663,294	705,120	0.573714	66.00
69.00	06900	ELECTROCARDIOLOGY	4,072	181,348	185,420	0.055226	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,114	3,114	0.751445	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	125,363	149,409	274,772	0.378863	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	128,108	1,622,398	1,750,506	0.387081	73.00
76.00	03140	CARDIOLOGY	0	0	0	0.000000	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	135,874	135,874	0.891863	76.01
76.97	07697	CARDIAC REHABILITATION	5,000	74,345	79,345	0.524633	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,408	770,251	771,659	1.675780	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	206,570	206,570	1.197822	88.01
90.00	09000	CLINIC	2,500	91,690	94,190	0.946672	90.00
90.01	04950	SLEEP LAB	3,000	102,768	105,768	0.311919	90.01
90.02	09001	GENERAL SURGERY CL	0	23,615	23,615	0.897692	90.02
90.03	09002	PM PAIN CLINIC	0	20,437	20,437	2.288105	90.03
91.00	09100	EMERGENCY	18,201	2,157,019	2,175,220	0.388627	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,187	261,184	262,371	1.342302	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	13,950	13,950		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	1,622,355	16,221,396	17,843,751		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	1,622,355	16,221,396	17,843,751		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/30/2021 2:08 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 05/01/2021 To 06/30/2021	Worksheet D Part II Date/Time Prepared: 11/30/2021 2:08 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	94,065	2,849,425	0.033012	159,553	5,267	50.00
53.00 05300 ANESTHESIOLOGY	12,038	215,588	0.055838	12,509	698	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	68,301	704,497	0.096950	23,417	2,270	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	3,947	558,181	0.007071	0	0	55.00
56.00 05600 RADIOISOTOPE	2,551	162,451	0.015703	3,362	53	56.00
57.00 05700 CT SCAN	6,744	2,175,865	0.003099	20,928	65	57.00
58.00 05800 MRI	4,659	524,675	0.008880	5,062	45	58.00
60.00 06000 LABORATORY	35,138	3,052,906	0.011510	90,560	1,042	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	536	65,202	0.008221	11,079	91	63.00
65.00 06500 RESPIRATORY THERAPY	9,690	226,131	0.042851	82,088	3,518	65.00
66.00 06600 PHYSICAL THERAPY	19,043	705,120	0.027007	18,212	492	66.00
69.00 06900 ELECTROCARDIOLOGY	1,304	185,420	0.007033	3,973	28	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	551	3,114	0.176943	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	3,286	274,772	0.011959	43,431	519	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	18,973	1,750,506	0.010839	85,213	924	73.00
76.00 03140 CARDIOLOGY	0	0	0.000000	0	0	76.00
76.01 03950 SENIOR BEHAVIORAL WELLNESS	4,987	135,874	0.036703	0	0	76.01
76.97 07697 CARDIAC REHABILITATION	3,543	79,345	0.044653	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	32,627	771,659	0.042282	0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	5,723	206,570	0.027705	0	0	88.01
90.00 09000 CLINIC	13,955	94,190	0.148158	0	0	90.00
90.01 04950 SLEEP LAB	2,086	105,768	0.019722	1,637	32	90.01
90.02 09001 GENERAL SURGERY CL	5,025	23,615	0.212788	0	0	90.02
90.03 09002 PM PAIN CLINIC	4,517	20,437	0.221021	0	0	90.03
91.00 09100 EMERGENCY	41,945	2,175,220	0.019283	1,202	23	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	27,096	262,371	0.103274	783	81	92.00
200.00 Total (lines 50 through 199)	422,330	17,328,902		563,009	15,148	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN:14-1337 Period: From 05/01/2021 To 06/30/2021 Worksheet D Part IV Date/Time Prepared: 11/30/2021 2:08 pm

Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	
		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 05/01/2021 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/30/2021 2:08 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
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,849,425	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	215,588	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	704,497	0.000000	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	558,181	0.000000	55.00	
56.00	05600	RADIOISOTOPE	0	0	0	162,451	0.000000	56.00	
57.00	05700	CT SCAN	0	0	0	2,175,865	0.000000	57.00	
58.00	05800	MRI	0	0	0	524,675	0.000000	58.00	
60.00	06000	LABORATORY	0	0	0	3,052,906	0.000000	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	65,202	0.000000	63.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	226,131	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	705,120	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	185,420	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,114	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	274,772	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,750,506	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	135,874	0.000000	76.01	
76.97	07697	CARDIAC REHABILITATION	0	0	0	79,345	0.000000	76.97	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	771,659	0.000000	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	206,570	0.000000	88.01	
90.00	09000	CLINIC	0	0	0	94,190	0.000000	90.00	
90.01	04950	SLEEP LAB	0	0	0	105,768	0.000000	90.01	
90.02	09001	GENERAL SURGERY CL	0	0	0	23,615	0.000000	90.02	
90.03	09002	PM PAIN CLINIC	0	0	0	20,437	0.000000	90.03	
91.00	09100	EMERGENCY	0	0	0	2,175,220	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	262,371	0.000000	92.00	
200.00		Total (lines 50 through 199)	0	0	0	17,328,902		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN:14-1337 Period: From 05/01/2021 To 06/30/2021 Worksheet D Part IV Date/Time Prepared: 11/30/2021 2:08 pm

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	159,553	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	12,509	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	23,417	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	3,362	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	20,928	0	0	0	57.00
58.00	05800 MRI	0.000000	5,062	0	0	0	58.00
60.00	06000 LABORATORY	0.000000	90,560	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	11,079	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.000000	82,088	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	18,212	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	3,973	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	43,431	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	85,213	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	1,637	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	1,202	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	783	0	0	0	92.00
200.00	Total (lines 50 through 199)		563,009	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN:14-1337		Period: From 05/01/2021 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/30/2021 2:08 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	0.414438	0	1,001,859	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.154795	0	67,052	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.700733	0	365,378	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.223204	0	105,057	0	0	55.00
56.00	05600	RADIOISOTOPE	0.332716	0	82,232	0	0	56.00
57.00	05700	CT SCAN	0.075666	0	814,460	0	0	57.00
58.00	05800	MRI	0.175139	0	193,462	0	0	58.00
60.00	06000	LABORATORY	0.264701	0	1,101,125	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.354084	0	34,744	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.889126	0	28,664	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.573714	0	275,626	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.055226	0	104,943	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.751445	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	0.378863	0	31,135	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387081	0	914,581	0	0	73.00
76.00	03140	CARDIOLOGY	0.000000	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0.891863	0	113,121	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.524633	0	42,076	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	0.946672	0	24,939	0	0	90.00
90.01	04950	SLEEP LAB	0.311919	0	11,255	0	0	90.01
90.02	09001	GENERAL SURGERY CL	0.897692	0	5,719	0	0	90.02
90.03	09002	PM PAIN CLINIC	2.288105	0	6,246	0	0	90.03
91.00	09100	EMERGENCY	0.388627	0	641,822	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.342302	0	119,147	0	0	92.00
200.00		Subtotal (see instructions)		0	6,084,643	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0	0	201.00
202.00		Only Charges						
202.00		Net Charges (line 200 - line 201)		0	6,084,643	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet D Part V Date/Time Prepared: 11/30/2021 2:08 pm
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			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	415,208	0	50.00
53.00	05300	ANESTHESIOLOGY	10,379	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	256,032	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	23,449	0	55.00
56.00	05600	RADIOISOTOPE	27,360	0	56.00
57.00	05700	CT SCAN	61,627	0	57.00
58.00	05800	MRI	33,883	0	58.00
60.00	06000	LABORATORY	291,469	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12,302	0	63.00
65.00	06500	RESPIRATORY THERAPY	25,486	0	65.00
66.00	06600	PHYSICAL THERAPY	158,130	0	66.00
69.00	06900	ELECTROCARDIOLOGY	5,796	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	11,796	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	354,017	0	73.00
76.00	03140	CARDIOLOGY	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	100,888	0	76.01
76.97	07697	CARDIAC REHABILITATION	22,074	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	23,609	0	90.00
90.01	04950	SLEEP LAB	3,511	0	90.01
90.02	09001	GENERAL SURGERY CL	5,134	0	90.02
90.03	09002	PM PAIN CLINIC	14,292	0	90.03
91.00	09100	EMERGENCY	249,429	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	159,931	0	92.00
200.00		Subtotal (see instructions)	2,265,802	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	2,265,802	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet D Part V Date/Time Prepared: 11/30/2021 2:08 pm
			Component CCN:14-Z337		
			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	0.414438	0	0	0	0 50.00
53.00 05300 ANESTHESIOLOGY	0.154795	0	0	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.700733	0	0	0	0 54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.223204	0	0	0	0 55.00
56.00 05600 RADIOISOTOPE	0.332716	0	0	0	0 56.00
57.00 05700 CT SCAN	0.075666	0	0	0	0 57.00
58.00 05800 MRI	0.175139	0	0	0	0 58.00
60.00 06000 LABORATORY	0.264701	0	0	0	0 60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.354084	0	0	0	0 63.00
65.00 06500 RESPIRATORY THERAPY	0.889126	0	0	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0.573714	0	0	0	0 66.00
69.00 06900 ELECTROCARDIOLOGY	0.055226	0	0	0	0 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.751445	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	0.378863	0	0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.387081	0	0	0	0 73.00
76.00 03140 CARDIOLOGY	0.000000	0	0	0	0 76.00
76.01 03950 SENIOR BEHAVIORAL WELLNESS	0.891863	0	0	0	0 76.01
76.97 07697 CARDIAC REHABILITATION	0.524633	0	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	0.946672	0	0	0	0 90.00
90.01 04950 SLEEP LAB	0.311919	0	0	0	0 90.01
90.02 09001 GENERAL SURGERY CL	0.897692	0	0	0	0 90.02
90.03 09002 PM PAIN CLINIC	2.288105	0	0	0	0 90.03
91.00 09100 EMERGENCY	0.388627	0	0	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1.342302	0	0	0	0 92.00
200.00 Subtotal (see instructions)		0	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	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet D Part V Date/Time Prepared: 11/30/2021 2:08 pm
		Component CCN:14-Z337		

				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

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 2:08 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)			302	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			296	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)			152	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			4	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			2	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			82	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)			4	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)			2	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)			738,600	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			14,674	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			723,926	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)			723,926	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)			2,445.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			200,547	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)			200,547	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 2:08 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			320,191	32	10,005.97	24	240,143	43.00
44.00	CORONARY CARE UNIT								44.00
45.00	BURN INTENSIVE CARE UNIT								45.00
46.00	SURGICAL INTENSIVE CARE UNIT								46.00
47.00	OTHER SPECIAL CARE (SPECIFY)								47.00
Cost Center Description									
									1.00
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)							251,075	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)							691,765	49.00
PASS THROUGH COST ADJUSTMENTS									
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)							0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)							0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)							0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION									
54.00	Program discharges							0	54.00
55.00	Target amount per discharge							0.00	55.00
56.00	Target amount (line 54 x line 55)							0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							0	57.00
58.00	Bonus payment (see instructions)							0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							0	61.00
62.00	Relief payment (see instructions)							0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)							0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST									
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)							9,783	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)							4,891	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)							14,674	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY									
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)								70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)								71.00
72.00	Program routine service cost (line 9 x line 71)								72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)								73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)								74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)								75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)								76.00
77.00	Program capital-related costs (line 9 x line 76)								77.00
78.00	Inpatient routine service cost (line 74 minus line 77)								78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)								79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)								80.00
81.00	Inpatient routine service cost per diem limitation								81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)								82.00
83.00	Reasonable inpatient routine service costs (see instructions)								83.00
84.00	Program inpatient ancillary services (see instructions)								84.00
85.00	Utilization review - physician compensation (see instructions)								85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)								86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
87.00	Total observation bed days (see instructions)							144	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)							2,445.70	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)							352,181	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/30/2021 2:08 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	56,827	738,600	0.076939	352,181	27,096
91.00	Nursing School cost	0	738,600	0.000000	352,181	0
92.00	Allied health cost	0	738,600	0.000000	352,181	0
93.00	All other Medical Education	0	738,600	0.000000	352,181	0

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/30/2021 2:08 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		169,676	30.00
31.00	03100	INTENSIVE CARE UNIT		55,596	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.414438	159,553	50.00
53.00	05300	ANESTHESIOLOGY	0.154795	12,509	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.700733	23,417	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.223204	0	55.00
56.00	05600	RADIOISOTOPE	0.332716	3,362	56.00
57.00	05700	CT SCAN	0.075666	20,928	57.00
58.00	05800	MRI	0.175139	5,062	58.00
60.00	06000	LABORATORY	0.264701	90,560	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.354084	11,079	63.00
65.00	06500	RESPIRATORY THERAPY	0.889126	82,088	65.00
66.00	06600	PHYSICAL THERAPY	0.573714	18,212	66.00
69.00	06900	ELECTROCARDIOLOGY	0.055226	3,973	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.751445	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.378863	43,431	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387081	85,213	73.00
76.00	03140	CARDIOLOGY	0.000000	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0.891863	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.524633	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	88.01
90.00	09000	CLINIC	0.946672	0	90.00
90.01	04950	SLEEP LAB	0.311919	1,637	90.01
90.02	09001	GENERAL SURGERY CL	0.897692	0	90.02
90.03	09002	PM PAIN CLINIC	2.288105	0	90.03
91.00	09100	EMERGENCY	0.388627	1,202	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.342302	783	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		563,009	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)		563,009	202.00

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN:14-1337	Period: From 05/01/2021	Worksheet D-3
			Component CCN:14-Z337	To 06/30/2021	Date/Time Prepared: 11/30/2021 2:08 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			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.414438	0	50.00
53.00	05300	ANESTHESIOLOGY	0.154795	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.700733	1,538	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.223204	0	55.00
56.00	05600	RADIOISOTOPE	0.332716	0	56.00
57.00	05700	CT SCAN	0.075666	0	57.00
58.00	05800	MRI	0.175139	0	58.00
60.00	06000	LABORATORY	0.264701	1,701	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.354084	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.889126	1,177	65.00
66.00	06600	PHYSICAL THERAPY	0.573714	4,735	66.00
69.00	06900	ELECTROCARDIOLOGY	0.055226	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.751445	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.378863	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387081	1,062	73.00
76.00	03140	CARDIOLOGY	0.000000	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0.891863	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.524633	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	0.946672	52	90.00
90.01	04950	SLEEP LAB	0.311919	0	90.01
90.02	09001	GENERAL SURGERY CL	0.897692	0	90.02
90.03	09002	PM PAIN CLINIC	2.288105	0	90.03
91.00	09100	EMERGENCY	0.388627	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.342302	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		10,265	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)		10,265	202.00

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/30/2021 2:08 pm	
		Title XVIII	Hospital	Cost	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)		2,265,802	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)		2,265,802	11.00	
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges		0	12.00	
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00	
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00	
Customary charges					
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00	
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00	
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00	
18.00	Total customary charges (see instructions)		0	18.00	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00	
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00	
21.00	Lesser of cost or charges (see instructions)		2,288,460	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)		9,433	25.00	
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,000,337	26.00	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,278,690	27.00	
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00	
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00	
30.00	Subtotal (sum of lines 27 through 29)		1,278,690	30.00	
31.00	Primary payer payments		396	31.00	
32.00	Subtotal (line 30 minus line 31)		1,278,294	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)		73,087	34.00	
35.00	Adjusted reimbursable bad debts (see instructions)		47,507	35.00	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		66,703	36.00	
37.00	Subtotal (see instructions)		1,325,801	37.00	
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00	
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97	
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98	
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99	
40.00	Subtotal (see instructions)		1,325,801	40.00	
40.01	Sequestration adjustment (see instructions)		0	40.01	
40.02	Demonstration payment adjustment amount after sequestration		0	40.02	
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03	
41.00	Interim payments		1,000,831	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)		324,970	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 05/01/2021
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/30/2021 2:08 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		368,601		1,000,831	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		368,601		1,000,831	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		282,449		324,970	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		651,050		1,325,801	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 05/01/2021
To 06/30/2021Part I
Date/Time Prepared:
11/30/2021 2:08 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		14,096		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		14,096		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		6,535		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		20,631		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 05/01/2021
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
11/30/2021 2:08 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

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet E-2	
		Component CCN:14-Z337		Date/Time Prepared: 11/30/2021 2:08 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)		14,821	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-3, col. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	Part	5,810	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		6	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)		20,631	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		20,631	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)		20,631	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		20,631	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)		20,631	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		14,096	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)		6,535	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))		66		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)		1 and		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

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet E-3 Part V Date/Time Prepared: 11/30/2021 2:08 pm	
		Title XVIII	Hospital	Cost	
				1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT					
1.00	Inpatient services			691,765	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)			691,765	4.00
5.00	Primary payer payments			0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			691,765	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)			691,765	19.00
20.00	Deductibles (exclude professional component)			43,036	20.00
21.00	Excess reasonable cost (from line 16)			0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)			648,729	22.00
23.00	Coinsurance			0	23.00
24.00	Subtotal (line 22 minus line 23)			648,729	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			3,570	25.00
26.00	Adjusted reimbursable bad debts (see instructions)			2,321	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			3,570	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			651,050	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)			651,050	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			368,601	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)			282,449	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:

Worksheet G

From 05/01/2021

Date/Time Prepared:

To 06/30/2021

11/30/2021 2:08 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	13,075,703	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	14,626,791	0	0	0	4.00
5.00	Other receivable	160,515	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,060,327	0	0	0	6.00
7.00	Inventory	485,931	0	0	0	7.00
8.00	Prepaid expenses	754,888	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)	21,043,501	0	0	0	11.00
FIXED ASSETS						
12.00	Land	681,222	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	23,857,322	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	40,481,135	0	0	0	23.00
24.00	Accumulated depreciation	-49,584,840	0	0	0	24.00
25.00	Minor equipment depreciable	63,979	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)	15,498,818	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,374,931	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,374,931	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	38,917,250	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	901,449	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,149,219	0	0	0	38.00
39.00	Payroll taxes payable	870,121	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,137,229	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,726,911	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,784,929	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,782,854	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,782,854	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	18,567,783	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	20,349,467	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)	20,349,467	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	38,917,250	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN:14-1337

Period:
From 05/01/2021
To 06/30/2021

Worksheet G-1

Date/Time Prepared:
11/30/2021 2:08 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		18,931,991		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		942,031				2.00
3.00	Total (sum of line 1 and line 2)		19,874,022		0		3.00
4.00	ADJUSTMENT	475,445		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)		475,445		0		10.00
11.00	Subtotal (line 3 plus line 10)		20,349,467		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)		20,349,467		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	ADJUSTMENT		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

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES			Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet G-2 Parts I & II Date/Time Prepared: 11/30/2021 2:08 pm
Cost Center Description			Inpatient	Outpatient	Total
			1.00	2.00	3.00
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital		758,251		758,251
2.00	SUBPROVIDER - IPF				
3.00	SUBPROVIDER - IRF				
4.00	SUBPROVIDER				
5.00	Swing bed - SNF		6,737		6,737
6.00	Swing bed - NF		0		0
7.00	SKILLED NURSING FACILITY				
8.00	NURSING FACILITY				
9.00	OTHER LONG TERM CARE				
10.00	Total general inpatient care services (sum of lines 1-9)		764,988		764,988
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT		114,663		114,663
12.00	CORONARY CARE UNIT				
13.00	BURN INTENSIVE CARE UNIT				
14.00	SURGICAL INTENSIVE CARE UNIT				
15.00	OTHER SPECIAL CARE (SPECIFY)				
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)		114,663		114,663
17.00	Total inpatient routine care services (sum of lines 10 and 16)		879,651		879,651
18.00	Ancillary services		1,096,131	15,725,121	16,821,252
19.00	Outpatient services		68,689	838,951	907,640
20.00	RURAL HEALTH CLINIC		7,398	850,630	858,028
20.01	RURAL HEALTH CLINIC II		0	215,759	215,759
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0
22.00	HOME HEALTH AGENCY			13,950	13,950
23.00	AMBULANCE SERVICES				
24.00	CMHC				
25.00	AMBULATORY SURGICAL CENTER (D.P.)				
26.00	HOSPICE				
27.00	OTHER NRCC		0	102,839	102,839
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. line 1)		G-3, 2,051,869	17,747,250	19,799,119
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			9,759,758	
30.00	GAIN/LOSS ON SALE OF ASSET		49,170		
31.00			0		
32.00			0		
33.00			0		
34.00			0		
35.00			0		
36.00	Total additions (sum of lines 30-35)			49,170	
37.00	DEDUCT (SPECIFY)		0		
38.00			0		
39.00			0		
40.00			0		
41.00			0		
42.00	Total deductions (sum of lines 37-41)			0	
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)			9,808,928	

STATEMENT OF REVENUES AND EXPENSES	Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet G-3 Date/Time Prepared: 11/30/2021 2:08 pm
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	19,799,119	1.00
2.00	Less contractual allowances and discounts on patients' accounts	14,199,611	2.00
3.00	Net patient revenues (line 1 minus line 2)	5,599,508	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	9,808,928	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,209,420	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	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	OTHER OPERATING INCOME	651,093	24.00
24.01	OTHER NON-OPERATING INCOME	75,858	24.01
24.50	COVID-19 PHE Funding	4,424,500	24.50
25.00	Total other income (sum of lines 6-24)	5,151,451	25.00
26.00	Total (line 5 plus line 25)	942,031	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	942,031	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS				Provider CCN:14-1337 HHA CCN: 14-7151		Period: From 05/01/2021 To 06/30/2021		Worksheet H Date/Time Prepared: 11/30/2021 2:08 pm	
						Home Health Agency I			
		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Pur- chased 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	1.00	
2.00	Capital Related - Movable Equipment			0		0	0	2.00	
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00	
4.00	Transportation	0	0	0	0	0	0	4.00	
5.00	Administrative and General	31,626	0	0	0	3,331	34,957	5.00	
HHA REIMBURSABLE SERVICES									
6.00	Skilled Nursing Care	8,346	0	0	0	879	9,225	6.00	
7.00	Physical Therapy	8,105	0	0	0	854	8,959	7.00	
8.00	Occupational Therapy	1,661	0	0	0	175	1,836	8.00	
9.00	Speech Pathology	92	0	0	0	10	102	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)	49,830	0	0	0	5,249	55,079	24.00	
		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	34,957	0	34,957			5.00	
HHA REIMBURSABLE SERVICES									
6.00	Skilled Nursing Care	0	9,225	0	9,225			6.00	
7.00	Physical Therapy	0	8,959	0	8,959			7.00	
8.00	Occupational Therapy	0	1,836	0	1,836			8.00	
9.00	Speech Pathology	0	102	0	102			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	55,079	0	55,079			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 HHA CCN: 14-7151		Period: From 05/01/2021 To 06/30/2021		Worksheet H-1 Part I Date/Time Prepared: 11/30/2021 2:08 pm	
							Home 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		4A.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	34,957	0	0	0	0	34,957	5.00		
HHA REIMBURSABLE SERVICES										
6.00	Skilled Nursing Care	9,225	0	0	0	0	9,225	6.00		
7.00	Physical Therapy	8,959	0	0	0	0	8,959	7.00		
8.00	Occupational Therapy	1,836	0	0	0	0	1,836	8.00		
9.00	Speech Pathology	102	0	0	0	0	102	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)	55,079	0	0	0	0	55,079	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	34,957						5.00		
HHA REIMBURSABLE SERVICES										
6.00	Skilled Nursing Care	16,026	25,251					6.00		
7.00	Physical Therapy	15,564	24,523					7.00		
8.00	Occupational Therapy	3,190	5,026					8.00		
9.00	Speech Pathology	177	279					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)		55,079					24.00		

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN:14-1337

Period:

Worksheet H-1

HHA CCN: 14-7151

From 05/01/2021
To 06/30/2021Part II
Date/Time Prepared:
11/30/2021 2:08 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	-34,957	20,122 5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	9,225	6.00
7.00	Physical Therapy	0	0	0	0	8,959	7.00
8.00	Occupational Therapy	0	0	0	0	1,836	8.00
9.00	Speech Pathology	0	0	0	0	102	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	-34,957	20,122 24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		34,957 25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		1.737253 26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN:14-1337

Period:

Worksheet H-2

HHA CCN: 14-7151

From 05/01/2021
To 06/30/2021Part I
Date/Time Prepared:
11/30/2021 2:08 pmHome Health
Agency I

Cost Center Description		CAPITAL RELATED COSTS					HENRY CLINIC	
		HHA Trial Balance (1)	BLDG & FIXT	PERRY PLAZA B&F	PROMPT CARE	WALNUT CLINIC		
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	25,251	668	0	0	0	0	2.00
3.00	Physical Therapy	24,523	0	0	0	0	0	3.00
4.00	Occupational Therapy	5,026	0	0	0	0	0	4.00
5.00	Speech Pathology	279	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)	55,079	668	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 decimal places.	6						21.00
Cost Center Description		CAPITAL RELATED COSTS		BUSINESS OFFICE	Subtotal	A&G HOSPITAL-ONLY	Subtotal	
		MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT					
		2.00	4.00					
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	198	26,117	3,760	29,877	2.00
3.00	Physical Therapy	0	0	0	24,523	3,531	28,054	3.00
4.00	Occupational Therapy	0	0	0	5,026	724	5,750	4.00
5.00	Speech Pathology	0	0	0	279	40	319	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	0	198	55,945	8,055	64,000	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 decimal places.	6			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 05/01/2021
To 06/30/2021Part I
Date/Time Prepared:
11/30/2021 2:08 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	8,399	3,215	0	0	0	0	2.00
3.00	Physical Therapy	7,887	0	0	0	0	0	3.00
4.00	Occupational Therapy	1,617	0	0	0	0	0	4.00
5.00	Speech Pathology	90	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)	17,993	3,215	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	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) (2)	0	0	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 05/01/2021
To 06/30/2021Part I
Date/Time Prepared:
11/30/2021 2:08 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	4,203	0	10	0	306	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	4,203	0	10	0	306	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 decimal places.	6						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	46,010	0	46,010	0	46,010	2.00
3.00	Physical Therapy	0	35,941	0	35,941	0	35,941	3.00
4.00	Occupational Therapy	0	7,367	0	7,367	0	7,367	4.00
5.00	Speech Pathology	0	409	0	409	0	409	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	89,727	0	89,727	0	89,727	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 decimal places.	6				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: From 05/01/2021 To 06/30/2021	Worksheet H-2 Part II Date/Time Prepared: 11/30/2021 2:08 pm		
				HHA CCN: 14-7151	Home 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	574	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)	574	0	0	0	0	0	20.00
21.00	Total cost to be allocated	668	0	0	0	0	0	21.00
22.00	Unit cost multiplier	1.163763	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	49,831	13,950	0	26,117	0	29,877	2.00
3.00	Physical Therapy	0	0	0	24,523	0	28,054	3.00
4.00	Occupational Therapy	0	0	0	5,026	0	5,750	4.00
5.00	Speech Pathology	0	0	0	279	0	319	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)	49,831	13,950		55,945		64,000	20.00
21.00	Total cost to be allocated	0	198		8,055		17,993	21.00
22.00	Unit cost multiplier	0.000000	0.014194		0.143981		0.281141	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS				Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet H-2 Part II Date/Time Prepared: 11/30/2021 2:08 pm
				HHA CCN: 14-7151	Home Health Agency I	
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
2.00 Skilled Nursing Care	574	0	0	0	0	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)	574	0	0	0	0	0
21.00 Total cost to be allocated	3,215	0	0	0	0	0
22.00 Unit cost multiplier	5.601045	0.000000	0.000000	0.000000	0.000000	0.000000
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
2.00 Skilled Nursing Care	0	0	0	0	0	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)	0	0	0	0	0	0
21.00 Total cost to be allocated	0	0	0	0	0	0
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS				Provider CCN:14-1337 HHA CCN: 14-7151		Period: From 05/01/2021 To 06/30/2021		Worksheet H-2 Part II Date/Time Prepared: 11/30/2021 2:08 pm	
						Home Health Agency I			
Cost Center Description		CAFETERIA (FTE'S SERV ED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (PATIENT DA YS)		
		11.00	13.00	14.00	15.00	16.00	17.00		
1.00	Administrative and General	0	0	0	0	0	0	1.00	
2.00	Skilled Nursing Care	270	0	44	0	13,950	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)	270	0	44	0	13,950	0	20.00	
21.00	Total cost to be allocated	4,203	0	10	0	306	0	21.00	
22.00	Unit cost multiplier	15.566667	0.000000	0.227273	0.000000	0.021935	0.000000	22.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN:14-1337

Period:

Worksheet H-3

HHA CCN: 14-7151

From 05/01/2021
To 06/30/2021Part I
Date/Time Prepared:
11/30/2021 2:08 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	46,010		46,010	68	676.62	1.00	
2.00	Physical Therapy	3.00	35,941	0	35,941	82	438.30	2.00	
3.00	Occupational Therapy	4.00	7,367	0	7,367	12	613.92	3.00	
4.00	Speech Pathology	5.00	409	0	409	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)		89,727	0	89,727	162		7.00	
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits				
					Part B				
		0	1.00	2.00	3.00	4.00	5.00		
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles			
Limitation Cost Computation									
8.00	Skilled Nursing Care		37900	0	2			8.00	
8.01	Skilled Nursing Care		99914	0	48			8.01	
9.00	Physical Therapy		37900	0	9			9.00	
9.01	Physical Therapy		99914	0	52			9.01	
10.00	Occupational Therapy		37900	0	0			10.00	
10.01	Occupational Therapy		99914	0	11			10.01	
11.00	Speech Pathology		37900	0	0			11.00	
11.01	Speech Pathology		99914	0	0			11.01	
12.00	Medical Social Services		37900	0	0			12.00	
12.01	Medical Social Services		99914	0	0			12.01	
13.00	Home Health Aide		37900	0	0			13.00	
13.01	Home Health Aide		99914	0	0			13.01	
14.00	Total (sum of lines 8-13)			0	122			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			
			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		
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	50		0	33,831		1.00	
2.00	Physical Therapy	0	61		0	26,736		2.00	
3.00	Occupational Therapy	0	11		0	6,753		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	0		0	0		6.00	
7.00	Total (sum of lines 1-6)	0	122		0	67,320		7.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN:14-1337

Period:

Worksheet H-3

HHA CCN: 14-7151

From 05/01/2021
To 06/30/2021Part I
Date/Time Prepared:
11/30/2021 2:08 pm

Title XVIII

Home Health
Agency I

Cost Center Description								
		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
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
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
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	660	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	33,831						1.00
2.00	Physical Therapy	26,736						2.00
3.00	Occupational Therapy	6,753						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)	67,320						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
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 05/01/2021
To 06/30/2021Part II
Date/Time Prepared:
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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	0.573714	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	0.387081	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN:14-1337 HHA CCN: 14-7151	Period: From 05/01/2021 To 06/30/2021	Worksheet H-4 Part I-II Date/Time Prepared: 11/30/2021 2:08 pm
		Title XVIII	Home Health Agency I	
		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
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
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
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			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	13,023	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	1,446	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	134	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	1,199	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	923	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	1,897	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	18,622	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	18,622	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	18,622	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	18,622	29.00
30.00	OTHER ADJUSTMENTS	0	0	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	18,622	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	18,622	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 PROGRAM BENEFICIARIES		Provider CCN:14-1337 HHA CCN: 14-7151		Period: From 05/01/2021 To 06/30/2021		Worksheet H-5 Date/Time Prepared: 11/30/2021 2:08 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		18,622	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			0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50			0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		18,622	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		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50			0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		0		18,622	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER			In Lieu of Form CMS-2552-10				
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS				Provider CCN:14-1337 Component CCN:14-8549		Period: From 05/01/2021 To 06/30/2021		Worksheet M-1 Date/Time Prepared: 11/30/2021 2:08 pm	
				RHC I		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassification 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	273,564	0	273,564	44,414	317,978	1.00		
2.00	Physician Assistant	0	0	0	0	0	2.00		
3.00	Nurse Practitioner	96,375	0	96,375	0	96,375	3.00		
4.00	Visiting Nurse	0	0	0	0	0	4.00		
5.00	Other Nurse	141,282	0	141,282	0	141,282	5.00		
6.00	Clinical Psychologist	0	0	0	0	0	6.00		
7.00	Clinical Social Worker	10,464	0	10,464	0	10,464	7.00		
8.00	Laboratory Technician	0	0	0	0	0	8.00		
9.00	Other Facility Health Care Staff Costs	109,379	14,939	124,318	0	124,318	9.00		
10.00	Subtotal (sum of lines 1 through 9)	631,064	14,939	646,003	44,414	690,417	10.00		
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00		
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00		
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00		
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00		
15.00	Medical Supplies	0	4,034	4,034	0	4,034	15.00		
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00		
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00		
18.00	Professional Liability Insurance	0	0	0	0	0	18.00		
19.00	Other Health Care Costs	0	0	0	0	0	19.00		
20.00	Allowable GME Costs	0	0	0	0	0	20.00		
21.00	Subtotal (sum of lines 15 through 20)	0	4,034	4,034	0	4,034	21.00		
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	631,064	18,973	650,037	44,414	694,451	22.00		
COSTS OTHER THAN RHC/FQHC SERVICES									
23.00	Pharmacy	0	14,427	14,427	0	14,427	23.00		
24.00	Dental	0	0	0	0	0	24.00		
25.00	Optometry	0	0	0	0	0	25.00		
25.01	Telehealth	5,024	0	5,024	0	5,024	25.01		
25.02	Chronic Care Management	0	0	0	0	0	25.02		
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00		
27.00	Nonallowable GME costs	0	0	0	0	0	27.00		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	5,024	14,427	19,451	0	19,451	28.00		
FACILITY OVERHEAD									
29.00	Facility Costs	0	6,991	6,991	0	6,991	29.00		
30.00	Administrative Costs	0	121,400	121,400	0	121,400	30.00		
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	128,391	128,391	0	128,391	31.00		
32.00	Total facility costs (sum of lines 22, 28 and 31)	636,088	161,791	797,879	44,414	842,293	32.00		

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN:14-1337

Period:

Worksheet M-1

Component CCN:14-8549

From 05/01/2021
To 06/30/2021Date/Time Prepared:
11/30/2021 2:08 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	317,978		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	96,375		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	141,282		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	10,464		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	-5,400	118,918		9.00
10.00	Subtotal (sum of lines 1 through 9)	-5,400	685,017		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	4,034		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	4,034		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-5,400	689,051		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	14,427		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	5,024		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	19,451		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	6,991		29.00
30.00	Administrative Costs	0	121,400		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	128,391		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-5,400	836,893		32.00

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER			In Lieu of Form CMS-2552-10				
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS				Provider CCN:14-1337 Component CCN:14-8583		Period: From 05/01/2021 To 06/30/2021		Worksheet M-1 Date/Time Prepared: 11/30/2021 2:08 pm	
						RHC II		Cost	
				Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassification 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		12,172	0	12,172	1,901	14,073	1.00	
2.00	Physician Assistant		3,851	0	3,851	0	3,851	2.00	
3.00	Nurse Practitioner		41,972	0	41,972	0	41,972	3.00	
4.00	Visiting Nurse		0	0	0	0	0	4.00	
5.00	Other Nurse		0	0	0	0	0	5.00	
6.00	Clinical Psychologist		0	0	0	0	0	6.00	
7.00	Clinical Social Worker		0	0	0	0	0	7.00	
8.00	Laboratory Technician		0	0	0	0	0	8.00	
9.00	Other Facility Health Care Staff Costs		75,260	0	75,260	0	75,260	9.00	
10.00	Subtotal (sum of lines 1 through 9)		133,255	0	133,255	1,901	135,156	10.00	
11.00	Physician Services Under Agreement		0	0	0	0	0	11.00	
12.00	Physician Supervision Under Agreement		0	0	0	0	0	12.00	
13.00	Other Costs Under Agreement		0	0	0	0	0	13.00	
14.00	Subtotal (sum of lines 11 through 13)		0	0	0	0	0	14.00	
15.00	Medical Supplies		0	2,501	2,501	0	2,501	15.00	
16.00	Transportation (Health Care Staff)		0	0	0	0	0	16.00	
17.00	Depreciation-Medical Equipment		0	0	0	0	0	17.00	
18.00	Professional Liability Insurance		0	0	0	0	0	18.00	
19.00	Other Health Care Costs		0	0	0	0	0	19.00	
20.00	Allowable GME Costs							20.00	
21.00	Subtotal (sum of lines 15 through 20)		0	2,501	2,501	0	2,501	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)		133,255	2,501	135,756	1,901	137,657	22.00	
COSTS OTHER THAN RHC/FQHC SERVICES									
23.00	Pharmacy		0	926	926	0	926	23.00	
24.00	Dental		0	0	0	0	0	24.00	
25.00	Optometry		0	0	0	0	0	25.00	
25.01	Telehealth		7,068	0	7,068	0	7,068	25.01	
25.02	Chronic Care Management		0	0	0	0	0	25.02	
26.00	All other nonreimbursable costs		0	0	0	0	0	26.00	
27.00	Nonallowable GME costs							27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)		7,068	926	7,994	0	7,994	28.00	
FACILITY OVERHEAD									
29.00	Facility Costs		0	5,675	5,675	0	5,675	29.00	
30.00	Administrative Costs		0	4,308	4,308	0	4,308	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)		0	9,983	9,983	0	9,983	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)		140,323	13,410	153,733	1,901	155,634	32.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN:14-1337

Period:

Worksheet M-1

Component CCN:14-8583

From 05/01/2021
To 06/30/2021Date/Time Prepared:
11/30/2021 2:08 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	14,073	1.00
2.00	Physician Assistant	0	3,851	2.00
3.00	Nurse Practitioner	0	41,972	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	75,260	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	135,156	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	2,501	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	2,501	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	137,657	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	926	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	7,068	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	7,994	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	5,675	29.00
30.00	Administrative Costs	0	4,308	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	9,983	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	155,634	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN:14-1337 Component CCN:14-8549	Period: From 05/01/2021 To 06/30/2021	Worksheet M-2 Date/Time Prepared: 11/30/2021 2:08 pm
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		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	0.56	2,188	4,200	2,352	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.40	1,099	2,100	840	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.96	3,287		3,192	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	0.18	199		199	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.14	3,486		3,486	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)				689,051	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				19,451	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				708,502	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.972546	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				128,391	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				456,238	15.00
16.00	Total overhead (sum of lines 14 and 15)				584,629	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				584,629	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				568,579	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				1,257,630	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES			Provider CCN:14-1337 Component CCN:14-8583		Period: From 05/01/2021 To 06/30/2021		Worksheet M-2 Date/Time Prepared: 11/30/2021 2:08 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	0.04	91	4,200	168			1.00
2.00	Physician Assistant	0.05	125	2,100	105			2.00
3.00	Nurse Practitioner	0.22	647	2,100	462			3.00
4.00	Subtotal (sum of lines 1 through 3)	0.31	863		735		863	4.00
5.00	Visiting Nurse	0.00	0				0	5.00
6.00	Clinical Psychologist	0.00	0				0	6.00
7.00	Clinical Social Worker	0.00	0				0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0				0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0				0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.31	863				863	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)						137,657	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)						7,994	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)						145,651	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)						0.945115	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)						9,983	14.00
15.00	Parent provider overhead allocated to facility (see instructions)						91,800	15.00
16.00	Total overhead (sum of lines 14 and 15)						101,783	16.00
17.00	Allowable GME overhead (see instructions)						0	17.00
18.00	Enter the amount from line 16						101,783	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)						96,197	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)						233,854	20.00

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet M-3	
		Component CCN:14-8549		Date/Time Prepared: 11/30/2021 2:08 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)			1,257,630	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			20,263	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,237,367	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,486	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)			3,486	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			354.95	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	254.97	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	254.97	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,191	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	303,669	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	303,669	16.00
16.01	Total program charges (see instructions)(from contractor's records)			213,839	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			21,054	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			29,898	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.)			205,353	16.04
16.05	Total program cost (see instructions)		0	235,251	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			17,080	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			35,141	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			235,251	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			10,675	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			245,926	22.00
23.00	Allowable bad debts (see instructions)			4,002	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			2,601	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			3,290	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)			248,527	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			233,865	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)			14,662	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		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet M-3	
		Component CCN:14-8583		Date/Time Prepared: 11/30/2021 2:08 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)			233,854	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			233,854	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			863	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)			863	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			270.98	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00		173.62	8.00
9.00	Rate for Program covered visits (see instructions)	0.00		173.62	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0		89	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0		15,452	11.00
12.00	Program covered visits for mental health services (from contractor records)	0		0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0		0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0		0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0		15,452	16.00
16.01	Total program charges (see instructions)(from contractor's records)			16,135	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			151	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			145	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.)			11,198	16.04
16.05	Total program cost (see instructions)	0		11,343	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			1,309	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			2,935	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			11,343	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			11,343	22.00
23.00	Allowable bad debts (see instructions)			29	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			19	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			29	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)			11,362	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			11,338	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)			24	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II chapter I, §115.2			0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN:14-1337

Period:

Worksheet M-4

Component CCN:14-8549

From 05/01/2021
To 06/30/2021Date/Time Prepared:
11/30/2021 2:08 pm

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	685,017	685,017	685,017	685,017	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000975	0.000029	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	668	20	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	10,380	34	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	11,048	54	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	689,051	689,051	689,051	689,051	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	568,579	568,579	568,579	568,579	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.016034	0.000078	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	9,117	44	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	20,165	98	0	0	10.00
11.00	Total number of injections/infusions (from your records)	68	2	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	296.54	49.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	36	0	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	10,675	0	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		20,263			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		10,675			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN:14-1337

Period:

Worksheet M-4

Component CCN:14-8583

From 05/01/2021
To 06/30/2021Date/Time Prepared:
11/30/2021 2:08 pm

		Title XVIII		RHC II	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	135,156	135,156	135,156	135,156	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000000	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	0	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	0	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	0	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	137,657	137,657	137,657	137,657	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	96,197	96,197	96,197	96,197	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.000000	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	0	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	0	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	0	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	0.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	0	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	0	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		0			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		0			16.00

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet M-5	
		Component CCN:14-8549		Date/Time Prepared: 11/30/2021 2:08 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		233,865	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			0		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		233,865		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		14,662		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		248,527		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00

Health Financial Systems		OSF SAINT CLARE MEDICAL CENTER		In Lieu of Form CMS-2552-10	
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-1337	Period: From 05/01/2021 To 06/30/2021	Worksheet M-5	
		Component CCN:14-8583		Date/Time Prepared: 11/30/2021 2:08 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		11,338	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			0		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		11,338		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		24		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		11,362		7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00