

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1337	Period: From 07/01/2021 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepared: 2/24/2022 11:43 am
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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 BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)
 MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by OSF SAINT CLARE MEDICAL CENTER (14-1337) for the cost reporting period beginning 07/01/2021 and ending 09/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-4,418	151,601	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	598	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		8,161		0	10.00
10.01 RURAL HEALTH CLINIC II	0		-5,597		0	10.01
200.00 Total	0	-3,820	154,165	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-1337		Period: From 07/01/2021 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/24/2022 11:43 am		
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
4.00	Subprovider - IPF										3.00
5.00	Subprovider - IRF										4.00
6.00	Subprovider - (Other)										5.00
7.00	Swing Beds - SNF			OSF SAINT CLARE MEDICAL CENTER	14Z337	99914		07/15/2004	N	O	N
8.00	Swing Beds - NF			OSF SAINT CLARE MEDICAL CENTER	14Z337	99914		07/15/2004	N		N
9.00	Hospital-Based SNF										7.00
10.00	Hospital-Based NF										8.00
11.00	Hospital-Based OLTC										9.00
12.00	Hospital-Based HHA			PERRY HOME CARE	147151	99914		05/01/2020	N	N	N
13.00	Separately Certified ASC										10.00
14.00	Hospital-Based Hospice										11.00
15.00	Hospital-Based Health Clinic - RHC			OSF HEALTHCARE - COMMUNITY HEALTH	148549	99914		11/04/2015	N	O	N
15.01	Hospital-Based Health Clinic - RHC II			OSF HEALTHCARE - PROMPT CARE	148583	99914		10/27/2017	N	O	N
16.00	Hospital-Based Health Clinic - FQHC										12.00
17.00	Hospital-Based (CMHC) I										13.00
18.00	Renal Dialysis										14.00
19.00	Other										15.00
								From:	To:		
								1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)							07/01/2021	09/30/2021		
21.00	Type of Control (see instructions)							1			
								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			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	N			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N	N		
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N	N		
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			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/24/2022 11:43 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
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		25.00
					Urban/Rural S 1.00	Date of Geogr 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: 1.00	Ending: 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 1.00	Y/N 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 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

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			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code				
			1.00	2.00	3.00				
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00		
			Y/N	IME	Direct GME	IME	Direct GME		
			1.00	2.00	3.00	4.00	5.00		
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00		
61.01	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		
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings									
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))				
			1.00	2.00	3.00				
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00	0.000000	64.00

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Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/24/2022 11:43 am

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
			1.00	2.00	3.00		
70.00	Inpatient Psychiatric Facility PPS						
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
	Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		Y	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1337	Period: From 07/01/2021 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/24/2022 11:43 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	60,944	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1337		Period: From 07/01/2021 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/24/2022 11:43 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							146.00	
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1337	Period: From 07/01/2021 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 2/24/2022 11:43 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	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	02/15/2022
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 a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	02/17/2022	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1337	Period: From 07/01/2021 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 2/24/2022 11:43 am
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	SPLITTING OF REVENUE CODES	Y	Y
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		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.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RANDY	HOFFMAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	SEIM JOHNSON, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	402-330-2660	RHOFFMAN@SEIMJOHNSON.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet S-2
Part II
Date/Time Prepared:
2/24/2022 11:43 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CPA, PARTNER	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 07/01/2021
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/24/2022 11:43 am

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	2,024	8,769.00	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	2,024	8,769.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	3	276	533.00	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	2,300	9,302.00	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 07/01/2021
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/24/2022 11:43 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	161	7	354			1.00
2.00	HMO and other (see instructions)	103	23				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	11	0	17			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)	172	7	371			7.00
8.00	INTENSIVE CARE UNIT	13	0	22			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)	185	7	393	0.00	173.95	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	0	0	0	0.00	0.00	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	1,633	0	4,369	0.00	30.24	26.00
26.01	RURAL HEALTH CLINIC II	245	0	1,756	0.00	7.03	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	211.22	27.00
28.00	Observation Bed Days		0	234			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 07/01/2021
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/24/2022 11:43 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	67	1	120	1.00
2.00 HMO and other (see instructions)			26	6		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	67	1	120	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	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1337 Component CCN: 14-8549		Period: From 07/01/2021 To 09/30/2021 Worksheet S-8 Date/Time Prepared: 2/24/2022 11:43 am	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	535 PARK AVENUE EAST		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	PRINCETON IL		61356	2.00
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
				5.00	
Facility hours of operations (1)					
11.00	CLINIC	07:00	17:30	07:00	11.00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?			12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	BUREAU		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
Facility hours of operations (1)					
11.00	CLINIC	17:30	07:00	17:30	07:00
		17:30		07:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1337

Period:

Worksheet S-8

Component CCN: 14-8549

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

Date/Time Prepared:

2/24/2022 11:43 am

RHC I

Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1337 Component CCN: 14-8583		Period: From 07/01/2021 To 09/30/2021		Worksheet S-8 Date/Time Prepared: 2/24/2022 11:43 am	
				RHC II		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			2128 N MAIN ST			1.00		
			City		State		ZIP Code		
			1.00		2.00		3.00		
2.00	City, State, ZIP Code, County			PRINCETON IL 61356			2.00		
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)						4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)						5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)						6.00		
7.00	Appalachian Regional Commission						7.00		
8.00	Look-Alikes						8.00		
9.00	OTHER (SPECIFY)						9.00		
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC			08:30 14:00		08:30 20:00		08:30 11.00	
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							14.00	
				Y/N		V		XVIII	
				1.00		2.00		3.00	
								XIX	
								Total Visits	
								5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			BUREAU				2.00	
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00 7.00		8.00 9.00		10.00	
Facility hours of operations (1)									
11.00	CLINIC			20:00 08:30		20:00 08:30		20:00 11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1337

Period:

Worksheet S-8

Component CCN: 14-8583

From 07/01/2021
To 09/30/2021Date/Time Prepared:
2/24/2022 11:43 am

RHC II

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1337

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

Worksheet S-10

Date/Time Prepared:
2/24/2022 11:43 am

			2/24/2022 11:43 am	
			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.398783	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,141,456	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		4,284,013	6.00
7.00	Medicaid cost (line 1 times line 6)		1,708,392	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)		566,936	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		566,936	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	
			3.00	
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	48,097	102,697	150,794
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	19,180	102,697	121,877
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	19,180	102,697	121,877
			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	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,639,011	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		46,802	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		72,004	
28.00	Non-Medicare bad debt expense (see instructions)		1,567,007	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		650,098	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		771,975	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,338,911	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1337

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

Worksheet A

Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	-133,043	-133,043	359,352	226,309	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	315	315	0	315	1.03
1.04	00104	HENRY CLINIC	756	756	0	756	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	355,637	355,637	-346,347	9,290	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	154,717	116,149	270,866	270,866	4.00
5.01	00590	BUSINESS OFFICE	184,295	188,987	373,282	51,237	5.01
5.02	00591	A&G HOSPITAL-ONLY	22,991	311,741	334,732	-24,947	5.02
5.03	00592	A&G SHARED	175,025	1,361,629	1,536,654	-11,734	5.03
7.00	00700	OPERATION OF PLANT	88,254	520,451	608,705	608,705	7.00
7.01	00701	PERRY PLAZA PLANT OP	0	0	0	0	7.01
7.02	00702	PROMPT CARE PLANT OP	0	3,830	3,830	0	7.02
7.03	00703	WALNUT CLINIC PLANT OP	0	2,366	2,366	0	7.03
7.04	00704	HENRY CLINIC PLANT OP	0	2,168	2,168	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	7,141	2,637	9,778	24,947	8.00
9.00	00900	HOUSEKEEPING	72,001	61,320	133,321	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	0	9.03
9.04	00904	HENRY CLINIC HSKPING	0	0	0	0	9.04
10.00	01000	DIETARY	57,248	130,052	187,300	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	83,764	21,941	105,705	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	29,484	33,192	62,676	0	14.00
15.00	01500	PHARMACY	71,385	100,479	171,864	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	76,396	42,123	118,519	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,853	1,853	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	340,841	143,529	484,370	0	30.00
31.00	03100	INTENSIVE CARE UNIT	14,388	8,769	23,157	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	227,228	197,953	425,181	0	50.00
53.00	05300	ANESTHESIOLOGY	0	224,899	224,899	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	179,930	129,259	309,189	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	51,715	43,120	94,835	0	55.00
56.00	05600	RADIOISOTOPE	0	41,485	41,485	0	56.00
57.00	05700	CT SCAN	0	42,073	42,073	0	57.00
58.00	05800	MRI	19,730	28,292	48,022	0	58.00
60.00	06000	LABORATORY	161,237	295,615	456,852	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	20,192	20,192	0	63.00
65.00	06500	RESPIRATORY THERAPY	98,105	27,295	125,400	0	65.00
66.00	06600	PHYSICAL THERAPY	133,884	35,498	169,382	0	66.00
68.00	06800	SPEECH PATHOLOGY	1,347	113	1,460	0	68.00
69.00	06900	ELECTROCARDIOLOGY	265	9,056	9,321	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	35,005	35,005	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	117,408	117,408	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	334,616	334,616	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	104,420	104,420	0	76.01
76.97	07697	CARDIAC REHABILITATION	49,219	11,124	60,343	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	639,070	267,244	906,314	-32,065	88.00
88.01	08801	RURAL HEALTH CLINIC II	137,608	55,644	193,252	-19,172	88.01
90.00	09000	CLINIC	394,908	126,319	521,227	0	90.00
90.01	04950	SLEEP LAB	16,829	4,525	21,354	0	90.01
90.02	09001	GENERAL SURGERY CL	115,208	57,165	172,373	0	90.02
90.03	09002	PM PAIN CLINIC	0	72,474	72,474	0	90.03
91.00	09100	EMERGENCY	311,129	715,543	1,026,672	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		1,271	1,271	-1,271	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,915,342	6,274,489	10,189,831	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,342	17,342	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	55,763	21,868	77,631	0	194.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1337

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

Worksheet A

Date/Time Prepared:
2/24/2022 11:43 am

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	
194.01	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		TOTAL (SUM OF LINES 118 through 199)	3,971,105	6,313,699	10,284,804	0	10,284,804	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1337

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

Worksheet A

Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	19,285	245,594	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	315	1.03
1.04	00104	HENRY CLINIC	0	756	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	383,491	392,781	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	270,866	4.00
5.01	00590	BUSINESS OFFICE	1,217,932	1,642,451	5.01
5.02	00591	A&G HOSPITAL-ONLY	0	309,785	5.02
5.03	00592	A&G SHARED	-247,734	1,277,186	5.03
7.00	00700	OPERATION OF PLANT	-2,867	605,838	7.00
7.01	00701	PERRY PLAZA PLANT OP	0	0	7.01
7.02	00702	PROMPT CARE PLANT OP	0	3,830	7.02
7.03	00703	WALNUT CLINIC PLANT OP	0	2,366	7.03
7.04	00704	HENRY CLINIC PLANT OP	0	2,168	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	34,725	8.00
9.00	00900	HOUSEKEEPING	0	133,321	9.00
9.01	00901	PERRY PLAZA HSKPING	0	0	9.01
9.02	00902	PROMPT CARE HSKPING	0	0	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	-20,949	166,351	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	92,354	198,059	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,517	77,193	14.00
15.00	01500	PHARMACY	0	171,864	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	118,519	16.00
17.00	01700	SOCIAL SERVICE	65,371	67,224	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-34,641	449,729	30.00
31.00	03100	INTENSIVE CARE UNIT	0	23,157	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	425,181	50.00
53.00	05300	ANESTHESIOLOGY	-219,925	4,974	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	309,189	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-4,831	90,004	55.00
56.00	05600	RADIOISOTOPE	0	41,485	56.00
57.00	05700	CT SCAN	0	42,073	57.00
58.00	05800	MRI	0	48,022	58.00
60.00	06000	LABORATORY	-9,315	447,537	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	20,192	63.00
65.00	06500	RESPIRATORY THERAPY	0	125,400	65.00
66.00	06600	PHYSICAL THERAPY	0	169,382	66.00
68.00	06800	SPEECH PATHOLOGY	0	1,460	68.00
69.00	06900	ELECTROCARDIOLOGY	-8,855	466	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	35,005	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	117,408	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-6,008	328,608	73.00
76.00	03140	CARDIOLOGY	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	104,420	76.01
76.97	07697	CARDIAC REHABILITATION	0	60,343	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	874,249	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	174,080	88.01
90.00	09000	CLINIC	-285,014	236,213	90.00
90.01	04950	SLEEP LAB	0	21,354	90.01
90.02	09001	GENERAL SURGERY CL	-131,843	40,530	90.02
90.03	09002	PM PAIN CLINIC	-65,483	6,991	90.03
91.00	09100	EMERGENCY	-500,684	525,988	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	254,801	10,444,632	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,342	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	77,631	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	194.02

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1337

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

Worksheet A

Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
194.03	07953	MOB LEASED SPACE	0	0	194.03
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)	254,801	10,539,605	200.00

RECLASSIFICATIONS

Provider CCN: 14-1337

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

Worksheet A-6

Date/Time Prepared:
2/24/2022 11:43 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,271	1.00	
	TOTALS		0	1,271		
	B - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,432	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,302	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
	TOTALS		0	11,734		
	D - CONTRACT LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	24,947	1.00	
	TOTALS		0	24,947		
	G - IMPAIRMENT OF ASSETS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	353,649	1.00	
	TOTALS		0	353,649		
	H - RHC BILLING					
1.00	BUSINESS OFFICE	5.01	51,237	0	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		51,237	0		
500.00	Grand Total: Increases		51,237	391,601	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1337

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

Worksheet A-6

Date/Time Prepared:
2/24/2022 11:43 am

	Decreases						
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - INTEREST						
	INTEREST EXPENSE	113.00	0	1,271	11		1.00
	TOTALS		0	1,271			
	B - PROPERTY INSURANCE						
1.00	A&G SHARED	5.03	0	11,734	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
4.00		0.00	0	0	12		4.00
5.00		0.00	0	0	12		5.00
	TOTALS		0	11,734			
	D - CONTRACT LAUNDRY						
1.00	A&G HOSPITAL-ONLY	5.02	0	24,947	0		1.00
	TOTALS		0	24,947			
	G - IMPAIRMENT OF ASSETS						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	353,649	9		1.00
	TOTALS		0	353,649			
	H - RHC BILLING						
1.00	RURAL HEALTH CLINIC	88.00	32,065	0	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	19,172	0	0		2.00
	TOTALS		51,237	0			
500.00	Grand Total: Decreases		51,237	391,601			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet A-7
Part I
Date/Time Prepared:
2/24/2022 11:43 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	320,233	0	320,233	0	1.00	
2.00	Land Improvements	0	92,482	0	92,482	0	2.00	
3.00	Buildings and Fixtures	0	8,830,635	0	8,830,635	0	3.00	
4.00	Building Improvements	0	1,483,931	0	1,483,931	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	0	0	0	0	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	0	10,727,281	0	10,727,281	0	8.00	
9.00	Reconciling Items	0	-32,219	0	-32,219	0	9.00	
10.00	Total (line 8 minus line 9)	0	10,759,500	0	10,759,500	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	320,233	0					1.00
2.00	Land Improvements	92,482	0					
3.00	Buildings and Fixtures	8,830,635	0					
4.00	Building Improvements	1,483,931	0					4.00
5.00	Fixed Equipment	0	0					
6.00	Movable Equipment	0	0					
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	10,727,281	0					
9.00	Reconciling Items	-32,219	0					
10.00	Total (line 8 minus line 9)	10,759,500	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet A-7
Part II
Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	-133,043	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	315	0	0	0	0	1.03
1.04	HENRY CLINIC	756	0	0	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	355,637	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	223,665	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	-133,043				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	315				1.03
1.04	HENRY CLINIC	0	756				1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	355,637				2.00
3.00	Total (sum of lines 1-2)	0	223,665				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet A-7
Part III
Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	8,830,635	0	8,830,635	0.856132	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	1,483,931	0	1,483,931	0.143868	0	2.00
3.00	Total (sum of lines 1-2)	10,314,566	0	10,314,566	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	241,162	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	315	0	1.03
1.04	HENRY CLINIC	0	0	0	756	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	385,479	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	627,712	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	0	4,432	0	0	245,594	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	315	1.03
1.04	HENRY CLINIC	0	0	0	0	756	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	7,302	0	0	392,781	2.00
3.00	Total (sum of lines 1-2)	0	11,734	0	0	639,446	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1337

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

Worksheet A-8

Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	-1,271	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)						
1.01	Investment income - PERRY PLAZA B&F (chapter 2)			0 PERRY PLAZA B&F	1.01	0	1.01
1.02	Investment income - PROMPT CARE (chapter 2)			0 PROMPT CARE	1.02	0	1.02
1.03	Investment income - WALNUT CLINIC (chapter 2)			0 WALNUT CLINIC	1.03	0	1.03
1.04	Investment income - HENRY CLINIC (chapter 2)			0 HENRY CLINIC	1.04	0	1.04
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0 CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		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	-1,260,591			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	1,447,728			0	12.00
13.00	Laundry and linen service	B		0 LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-791	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0 RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0 PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0 CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - PERRY PLAZA B&F			0 PERRY PLAZA B&F	1.01	0	26.01
26.02	Depreciation - PROMPT CARE			0 PROMPT CARE	1.02	0	26.02
26.03	Depreciation - WALNUT CLINIC			0 WALNUT CLINIC	1.03	0	26.03
26.04	Depreciation - HENRY CLINIC			0 HENRY CLINIC	1.04	0	26.04
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0 CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0 *** Cost Center Deleted ***	19.00		28.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1337

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

Worksheet A-8

Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-282	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	CAFETERIA	B	-11,833	DIETARY	10.00	0	33.00
33.01	DIETICIAN REVENUE	B	-3,104	DIETARY	10.00	0	33.01
33.02	OUTSIDE CATERING	B	0	DIETARY	10.00	0	33.02
33.03	MEDICAL RECORDS	B	0	MEDICAL RECORDS & LIBRARY	16.00	0	33.03
33.04	CONTRACT NURSING	B	-10,913	NURSING ADMINISTRATION	13.00	0	33.04
33.05	MISCELLANEOUS	B	0	A&G SHARED	5.03	0	33.05
33.06	MOBILE MEALS	A	-5,221	DIETARY	10.00	0	33.06
33.07	GASB 68	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	TELEPHONE EXPENSE	A	-2,867	OPERATION OF PLANT	7.00	0	33.08
33.09	340B EXPENSE OFFSET	A	-6,008	DRUGS CHARGED TO PATIENTS	73.00	0	33.09
33.11	MEDICAL DIRECTOR TO A SNF	B	0	RURAL HEALTH CLINIC	88.00	0	33.11
33.12	AMORTIZATION EXPENSE	A	0	CAP REL COSTS-BLDG & FIXT	1.00	11	33.12
33.13	IMPAIRMENT OF ASSETS	A	-4,758	CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
33.14	IMPAIRMENT OF ASSETS	A	353,649	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.14
33.15	NON-ALLOWABLE MARKETING	A	-1,826	A&G SHARED	5.03	0	33.15
33.16	MARKETING BENEFITS	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.16
33.17	RENTAL PROPERTY - CAPITAL	A	0	CAP REL COSTS-BLDG & FIXT	1.00	9	33.17
33.18	IDPA PROVIDER TAX	A	-237,111	A&G SHARED	5.03	0	33.18
33.21	IHA DUES OFFSET	A	0	A&G SHARED	5.03	0	33.21
33.22	ALCOHOL EXP	A	0	A&G SHARED	5.03	0	33.22
33.23	PHYSICIAN ON CALL	A	0	A&G SHARED	5.03	0	33.23
33.24	SELF-INSURANCE OFFSET	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.24
33.25	UNFUNDED OTHER POST EMPLOYMENT BENEF	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.25
33.26	SOCIAL ORG. DUES - PRINCETON ROTARY	B	0	A&G SHARED	5.03	0	33.26
33.27	NON-ALLOWABLE NOTE INTEREST	A	0	CAP REL COSTS-BLDG & FIXT	1.00	11	33.27
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		254,801				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-1337

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

Worksheet A-8-1

Date/Time Prepared:
2/24/2022 11:43 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL BLDG HO BLDG CAPITAL	25,314	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	104,482	74,358	2.00
3.00	5.03	A&G SHARED	HO POOLED - ADMIN & GENERAL	777,565	808,973	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	MINISTRY ALLOCATION	71,682	71,682	3.01
3.02	7.00	OPERATION OF PLANT	MINISTRY ALLOCATION	15,276	15,276	3.02
3.03	66.00	PHYSICAL THERAPY	MINISTRY ALLOCATION	6,636	6,636	3.03
3.04	15.00	PHARMACY	MINISTRY ALLOCATION	10,917	10,917	3.04
3.05	5.03	A&G SHARED	HO FUNCTIONAL - ADMIN	22,611	0	3.05
3.06	14.00	CENTRAL SERVICES & SUPPLY	HO FUNCTIONAL - CS	14,517	0	3.06
3.07	13.00	NURSING ADMINISTRATION	HO FUNCTIONAL - NURSING ADMI	103,267	0	3.07
3.08	5.01	BUSINESS OFFICE	HO FUNCTIONAL - REVNEUE CYCL	1,217,932	0	3.08
3.09	17.00	SOCIAL SERVICE	HO FUNCTIONAL - CARE MANAGEM	65,371	0	3.09
3.10	7.00	OPERATION OF PLANT	SFI HEALTHCARE TECHNOLOGY SV	170,739	170,739	3.10
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,606,309	1,158,581	5.00

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

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

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

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

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

6.00	B	0.00	OSF HEALTHCARE	100.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 14-1337

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

Worksheet A-8-1

Date/Time Prepared:
2/24/2022 11:43 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	25,314	9		1.00
2.00	30,124	9		2.00
3.00	-31,408	0		3.00
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	22,611	0		3.05
3.06	14,517	0		3.06
3.07	103,267	0		3.07
3.08	1,217,932	0		3.08
3.09	65,371	0		3.09
3.10	0	0		3.10
4.00	0	0		4.00
5.00	1,447,728			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		

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

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1337

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

Worksheet A-8-2

Date/Time Prepared:
2/24/2022 11:43 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	34,641	34,641	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	219,925	219,925	0	0	0	3.00
4.00	55.00	RADIOLOGY-THERAPEUTIC	4,831	4,831	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	8,855	8,855	0	0	0	5.00
6.00	90.00	CLINIC	285,014	285,014	0	0	0	6.00
7.00	90.02	GENERAL SURGERY CL	131,843	131,843	0	0	0	7.00
8.00	90.03	PM PAIN CLINIC	65,483	65,483	0	0	0	8.00
9.00	91.00	EMERGENCY	591,129	500,684	90,445	0	0	9.00
10.00	60.00	LABORATORY	9,315	9,315	0	0	0	10.00
200.00			1,351,036	1,260,591	90,445		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	90.02	GENERAL SURGERY CL	0	0	0	0	0	7.00
8.00	90.03	PM PAIN CLINIC	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	60.00	LABORATORY	0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	34,641		1.00
2.00	50.00	OPERATING ROOM	0	0	0	0		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	219,925		3.00
4.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	4,831		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	8,855		5.00
6.00	90.00	CLINIC	0	0	0	285,014		6.00
7.00	90.02	GENERAL SURGERY CL	0	0	0	131,843		7.00
8.00	90.03	PM PAIN CLINIC	0	0	0	65,483		8.00
9.00	91.00	EMERGENCY	0	0	0	500,684		9.00
10.00	60.00	LABORATORY	0	0	0	9,315		10.00
200.00			0	0	0	1,260,591		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/24/2022 11:43 am

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	245,594	245,594			1.00
1.01	00101	PERRY PLAZA B&F	0	0	0		1.01
1.02	00102	PROMPT CARE	0	0	0		1.02
1.03	00103	WALNUT CLINIC	315	0	0	315	1.03
1.04	00104	HENRY CLINIC	756	0	0	0	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	392,781				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	270,866	849	0	0	4.00
5.01	00590	BUSINESS OFFICE	1,642,451	4,436	0	0	5.01
5.02	00591	A&G HOSPITAL-ONLY	309,785	8,865	0	0	5.02
5.03	00592	A&G SHARED	1,277,186	17,265	0	0	5.03
7.00	00700	OPERATION OF PLANT	605,838	69,096	0	0	7.00
7.01	00701	PERRY PLAZA PLANT OP	0	0	0	0	7.01
7.02	00702	PROMPT CARE PLANT OP	3,830	0	0	0	7.02
7.03	00703	WALNUT CLINIC PLANT OP	2,366	0	0	42	7.03
7.04	00704	HENRY CLINIC PLANT OP	2,168	0	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	34,725	908	0	0	8.00
9.00	00900	HOUSEKEEPING	133,321	1,888	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	166,351	5,688	0	0	10.00
11.00	01100	CAFETERIA	0	2,827	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	198,059	2,041	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	77,193	2,029	0	0	14.00
15.00	01500	PHARMACY	171,864	2,157	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	118,519	4,612	0	0	16.00
17.00	01700	SOCIAL SERVICE	67,224	688	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	449,729	22,387	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	23,157	3,932	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	425,181	21,912	0	0	50.00
53.00	05300	ANESTHESIOLOGY	4,974	198	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	309,189	4,084	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	90,004	377	0	0	55.00
56.00	05600	RADIOISOTOPE	41,485	973	0	0	56.00
57.00	05700	CT SCAN	42,073	1,105	0	0	57.00
58.00	05800	MRI	48,022	1,269	0	0	58.00
60.00	06000	LABORATORY	447,537	4,428	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	20,192	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	125,400	2,283	0	0	65.00
66.00	06600	PHYSICAL THERAPY	169,382	5,792	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	1,460	87	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	466	84	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	382	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	35,005	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	117,408	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	328,608	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	104,420	1,706	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	60,343	1,156	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	874,249	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	174,080	0	0	0	88.01
90.00	09000	CLINIC	236,213	11,186	0	0	90.00
90.01	04950	SLEEP LAB	21,354	767	0	0	90.01
90.02	09001	GENERAL SURGERY CL	40,530	3,249	0	0	90.02
90.03	09002	PM PAIN CLINIC	6,991	1,513	0	0	90.03
91.00	09100	EMERGENCY	525,988	9,884	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	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,444,632	222,103	0	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,342	730	0	0	190.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/24/2022 11:43 am

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	
				1.00	1.01	1.02	1.03	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	540	0	0	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	77,631	0	0	0	267	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	3,365	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	18,856	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)	10,539,605	245,594	0	0	315	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/24/2022 11:43 am

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	756					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		392,781				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	271,715			4.00
5.01	00590	BUSINESS OFFICE	0	0	16,769	1,663,656		5.01
5.02	00591	A&G HOSPITAL-ONLY	0	50,409	1,637	0	370,696	5.02
5.03	00592	A&G SHARED	0	74,888	12,461	0	1,381,800	5.03
7.00	00700	OPERATION OF PLANT	0	49,287	6,283	0	730,504	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	3,830	7.02
7.03	00703	WALNUT CLINIC PLANT OP	0	0	0	0	2,408	7.03
7.04	00704	HENRY CLINIC PLANT OP	196	0	0	0	2,364	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	508	0	36,141	8.00
9.00	00900	HOUSEKEEPING	0	756	5,126	0	141,091	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	0	0	6	9.03
9.04	00904	HENRY CLINIC HSKPING	30	0	0	0	30	9.04
10.00	01000	DIETARY	0	3,111	4,076	0	179,226	10.00
11.00	01100	CAFETERIA	0	0	0	0	2,827	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	5,964	0	206,064	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,802	2,099	0	84,123	14.00
15.00	01500	PHARMACY	0	2,847	5,082	0	181,950	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,025	5,439	0	129,595	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	67,912	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	9,691	24,267	58,443	564,517	30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,287	1,024	10,735	47,135	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	26,695	16,178	194,076	684,042	50.00
53.00	05300	ANESTHESIOLOGY	0	17,126	0	18,343	40,641	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	79,600	12,810	71,858	477,541	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	3,682	52,637	146,700	55.00
56.00	05600	RADIOISOTOPE	0	0	0	12,885	55,343	56.00
57.00	05700	CT SCAN	0	264	0	225,892	269,334	57.00
58.00	05800	MRI	0	767	1,405	50,937	102,400	58.00
60.00	06000	LABORATORY	0	11,607	11,480	293,286	768,338	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	5,531	25,723	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,948	6,985	17,833	155,449	65.00
66.00	06600	PHYSICAL THERAPY	0	2,067	9,532	67,777	254,550	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	96	661	2,304	68.00
69.00	06900	ELECTROCARDIOLOGY	0	766	19	18,255	19,590	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	471	853	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	15,373	50,378	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	13,481	130,889	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	150,062	478,670	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	0	12,747	118,873	76.01
76.97	07697	CARDIAC REHABILITATION	0	1,463	3,504	9,179	75,645	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	25,711	43,220	64,494	1,007,674	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	317	8,432	22,059	204,888	88.01
90.00	09000	CLINIC	0	6,018	28,116	47,269	328,802	90.00
90.01	04950	SLEEP LAB	0	361	1,198	13,639	37,319	90.01
90.02	09001	GENERAL SURGERY CL	0	0	8,202	721	52,702	90.02
90.03	09002	PM PAIN CLINIC	0	2,042	0	615	11,161	90.03
91.00	09100	EMERGENCY	0	11,926	22,151	214,397	784,346	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	0	0	101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	226	392,781	267,745	1,663,656	10,416,374	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	18,072	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	540	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/24/2022 11:43 am

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	
194.00	07956	WALNUT & HENRY CLINICS	530	0	3,970	0	82,398	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	3,365	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	18,856	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	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	756	392,781	271,715	1,663,656	10,539,605	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/24/2022 11:43 am

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	370,696					5.02
5.03	00592	A&G SHARED	50,371	1,432,171	1,432,171			5.03
7.00	00700	OPERATION OF PLANT	26,630	757,134	119,062	876,196		7.00
7.01	00701	PERRY PLAZA PLANT OP	0	0	0	0	0	7.01
7.02	00702	PROMPT CARE PLANT OP	140	3,970	624	0	0	7.02
7.03	00703	WALNUT CLINIC PLANT OP	88	2,496	393	0	0	7.03
7.04	00704	HENRY CLINIC PLANT OP	86	2,450	385	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	1,317	37,458	5,890	5,485	0	8.00
9.00	00900	HOUSEKEEPING	5,143	146,234	22,996	11,400	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	6	1	0	0	9.03
9.04	00904	HENRY CLINIC HSKPING	1	31	5	0	0	9.04
10.00	01000	DIETARY	6,534	185,760	29,211	34,351	0	10.00
11.00	01100	CAFETERIA	103	2,930	461	17,076	0	11.00
13.00	01300	NURSING ADMINISTRATION	7,512	213,576	33,585	12,323	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,067	87,190	13,711	12,252	0	14.00
15.00	01500	PHARMACY	6,633	188,583	29,655	13,024	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,724	134,319	21,122	27,855	0	16.00
17.00	01700	SOCIAL SERVICE	2,476	70,388	11,069	4,156	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,579	585,096	92,008	135,198	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,718	48,853	7,682	23,747	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	24,936	708,978	111,489	132,332	0	50.00
53.00	05300	ANESTHESIOLOGY	1,482	42,123	6,624	1,194	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,408	494,949	77,832	24,663	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,348	152,048	23,910	2,277	0	55.00
56.00	05600	RADIOISOTOPE	2,017	57,360	9,020	5,875	0	56.00
57.00	05700	CT SCAN	9,818	279,152	43,897	6,671	0	57.00
58.00	05800	MRI	3,733	106,133	16,690	7,666	0	58.00
60.00	06000	LABORATORY	28,009	796,347	125,228	26,740	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	938	26,661	4,193	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	5,667	161,116	25,336	13,788	0	65.00
66.00	06600	PHYSICAL THERAPY	9,279	263,829	41,488	34,980	0	66.00
68.00	06800	SPEECH PATHOLOGY	84	2,388	376	525	0	68.00
69.00	06900	ELECTROCARDIOLOGY	714	20,304	3,193	509	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	31	884	139	2,309	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,836	52,214	8,211	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,771	135,660	21,333	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,449	496,119	78,016	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	4,333	123,206	19,375	10,301	0	76.01
76.97	07697	CARDIAC REHABILITATION	2,758	78,403	12,329	6,982	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	36,734	1,044,408	164,235	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,469	212,357	33,394	0	0	88.01
90.00	09000	CLINIC	11,986	340,788	53,590	67,555	0	90.00
90.01	04950	SLEEP LAB	1,360	38,679	6,082	4,633	0	90.01
90.02	09001	GENERAL SURGERY CL	1,921	54,623	8,590	19,623	0	90.02
90.03	09002	PM PAIN CLINIC	407	11,568	1,819	9,139	0	90.03
91.00	09100	EMERGENCY	28,593	812,939	127,837	59,690	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	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)	366,203	10,411,881	1,412,086	734,319	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	659	18,731	2,946	4,410	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20	560	88	3,264	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	3,004	85,402	13,430	0	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	123	3,488	548	20,324	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/24/2022 11:43 am

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	
194.03	07953	MOB LEASED SPACE	687	19,543	3,073	113,879	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	0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	370,696	10,539,605	1,432,171	876,196	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/24/2022 11:43 am

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	4,594					7.02
7.03	00703	WALNUT CLINIC PLANT OP	0	2,889				7.03
7.04	00704	HENRY CLINIC PLANT OP	0	0	2,835			7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	48,833		8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	180,630	9.00
9.01	00901	PERRY PLAZA HSKPING	0	0	0	0	0	9.01
9.02	00902	PROMPT CARE HSKPING	202	0	0	0	0	9.02
9.03	00903	WALNUT CLINIC HSKPING	0	61	0	0	0	9.03
9.04	00904	HENRY CLINIC HSKPING	0	0	152	0	0	9.04
10.00	01000	DIETARY	0	0	0	0	2,562	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	4,575	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	350	2,379	14.00
15.00	01500	PHARMACY	0	0	0	0	1,647	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	549	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	2,928	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	10,800	37,151	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	1,413	4,026	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	14,263	39,533	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	628	0	0	2,300	9,699	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	1,829	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	291	0	56.00
57.00	05700	CT SCAN	0	0	0	1,817	1,830	57.00
58.00	05800	MRI	0	0	0	1,302	1,281	58.00
60.00	06000	LABORATORY	0	0	0	0	6,222	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	2,928	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,386	4,575	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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	2,196	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	915	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	211	28,915	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,764	0	0	88	732	88.01
90.00	09000	CLINIC	0	0	0	123	3,294	90.00
90.01	04950	SLEEP LAB	0	0	0	0	2,928	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	51	0	90.02
90.03	09002	PM PAIN CLINIC	0	0	0	0	3,660	90.03
91.00	09100	EMERGENCY	0	0	0	12,008	15,556	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)	4,594	61	152	48,232	180,081	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	2,828	2,683	601	549	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/24/2022 11:43 am

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	
194.03	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)	4,594	2,889	2,835	48,833	180,630	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/24/2022 11:43 am

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	202			9.02
9.03	00903	WALNUT CLINIC HSKPING	0	0	68		9.03
9.04	00904	HENRY CLINIC HSKPING	0	0	0	188	9.04
10.00	01000	DIETARY	0	0	0	0	251,884 10.00
11.00	01100	CAFETERIA	0	0	0	0	181,879 11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0 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	154 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	65,207 30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	4,644 31.00
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	29	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
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
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	173	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
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	202	0	0	251,884 118.00
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	68	188	0 194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	0 194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0 194.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/24/2022 11:43 am

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	
194.03	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)	0	202	68	188	251,884	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	PERRY PLAZA B&F						1.01
1.02	00102	PROMPT CARE						1.02
1.03	00103	WALNUT CLINIC						1.03
1.04	00104	HENRY CLINIC						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	BUSINESS OFFICE						5.01
5.02	00591	A&G HOSPITAL-ONLY						5.02
5.03	00592	A&G SHARED						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	PERRY PLAZA PLANT OP						7.01
7.02	00702	PROMPT CARE PLANT OP						7.02
7.03	00703	WALNUT CLINIC PLANT OP						7.03
7.04	00704	HENRY CLINIC PLANT OP						7.04
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	PERRY PLAZA HSKPING						9.01
9.02	00902	PROMPT CARE HSKPING						9.02
9.03	00903	WALNUT CLINIC HSKPING						9.03
9.04	00904	HENRY CLINIC HSKPING						9.04
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	202,346					11.00
13.00	01300	NURSING ADMINISTRATION	5,742	269,801				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,879	6,010	127,771			14.00
15.00	01500	PHARMACY	5,245	0	1,181	239,335		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,152	0	0	0	195,997	16.00
17.00	01700	SOCIAL SERVICE	0	0	11	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	33,627	98,376	4,755	0	6,885	30.00
31.00	03100	INTENSIVE CARE UNIT	1,148	3,354	1,147	0	1,265	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	19,796	57,941	16,862	0	22,864	50.00
53.00	05300	ANESTHESIOLOGY	0	0	1,469	0	2,161	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,213	0	259	0	8,466	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,148	0	1,772	0	6,201	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	1,518	56.00
57.00	05700	CT SCAN	0	0	2,373	0	26,612	57.00
58.00	05800	MRI	1,697	0	487	0	6,001	58.00
60.00	06000	LABORATORY	20,567	0	6,391	0	34,553	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	652	63.00
65.00	06500	RESPIRATORY THERAPY	10,352	0	0	0	2,101	65.00
66.00	06600	PHYSICAL THERAPY	11,123	0	1,144	0	7,985	66.00
68.00	06800	SPEECH PATHOLOGY	137	0	0	0	78	68.00
69.00	06900	ELECTROCARDIOLOGY	51	0	25	0	2,151	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	55	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	10,867	0	1,811	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	36,450	0	1,588	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	239,335	17,679	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	0	0	1,502	76.01
76.97	07697	CARDIAC REHABILITATION	3,496	0	183	0	1,081	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	2,962	0	7,598	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	2,754	0	2,599	88.01
90.00	09000	CLINIC	12,752	19,712	21,944	0	5,569	90.00
90.01	04950	SLEEP LAB	1,851	0	388	0	1,607	90.01
90.02	09001	GENERAL SURGERY CL	4,285	0	282	0	85	90.02
90.03	09002	PM PAIN CLINIC	0	0	2,010	0	72	90.03
91.00	09100	EMERGENCY	29,085	84,408	10,216	0	25,258	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)	202,346	269,801	125,932	239,335	195,997	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	852	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	987	0	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	0	194.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
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
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					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	202,346	269,801	127,771	239,335	195,997

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	PERRY PLAZA B&F					1.01
1.02	00102	PROMPT CARE					1.02
1.03	00103	WALNUT CLINIC					1.03
1.04	00104	HENRY CLINIC					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	BUSINESS OFFICE					5.01
5.02	00591	A&G HOSPITAL-ONLY					5.02
5.03	00592	A&G SHARED					5.03
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	PERRY PLAZA PLANT OP					7.01
7.02	00702	PROMPT CARE PLANT OP					7.02
7.03	00703	WALNUT CLINIC PLANT OP					7.03
7.04	00704	HENRY CLINIC PLANT OP					7.04
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
9.01	00901	PERRY PLAZA HSKPING					9.01
9.02	00902	PROMPT CARE HSKPING					9.02
9.03	00903	WALNUT CLINIC HSKPING					9.03
9.04	00904	HENRY CLINIC HSKPING					9.04
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	88,706				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	84,641	1,153,744	0	1,153,744	30.00
31.00	03100	INTENSIVE CARE UNIT	4,065	101,344	0	101,344	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,124,058	0	1,124,058	50.00
53.00	05300	ANESTHESIOLOGY	0	53,571	0	53,571	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	638,038	0	638,038	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	192,185	0	192,185	55.00
56.00	05600	RADIOISOTOPE	0	74,064	0	74,064	56.00
57.00	05700	CT SCAN	0	362,352	0	362,352	57.00
58.00	05800	MRI	0	141,257	0	141,257	58.00
60.00	06000	LABORATORY	0	1,016,048	0	1,016,048	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	31,506	0	31,506	63.00
65.00	06500	RESPIRATORY THERAPY	0	215,621	0	215,621	65.00
66.00	06600	PHYSICAL THERAPY	0	366,510	0	366,510	66.00
68.00	06800	SPEECH PATHOLOGY	0	3,504	0	3,504	68.00
69.00	06900	ELECTROCARDIOLOGY	0	26,233	0	26,233	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,387	0	3,387	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	73,103	0	73,103	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	195,031	0	195,031	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	831,149	0	831,149	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	156,580	0	156,580	76.01
76.97	07697	CARDIAC REHABILITATION	0	103,389	0	103,389	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,248,329	0	1,248,329	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	255,861	0	255,861	88.01
90.00	09000	CLINIC	0	525,327	0	525,327	90.00
90.01	04950	SLEEP LAB	0	56,168	0	56,168	90.01
90.02	09001	GENERAL SURGERY CL	0	87,539	0	87,539	90.02
90.03	09002	PM PAIN CLINIC	0	28,268	0	28,268	90.03
91.00	09100	EMERGENCY	0	1,176,997	0	1,176,997	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	88,706	10,241,163	0	10,241,163	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,939	0	26,939	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,912	0	3,912	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	192.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
194.00	07956	WALNUT & HENRY CLINICS	0	106,736	0	106,736		194.00
194.01	07951	HOSPITAL LEASED SPACE	0	24,360	0	24,360		194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0		194.02
194.03	07953	MOB LEASED SPACE	0	136,495	0	136,495		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	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	88,706	10,539,605	0	10,539,605		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			BLDG & FIXT	PERRY PLAZA B&F	PROMPT CARE	WALNUT CLINIC	
		0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	PERRY PLAZA B&F					1.01
1.02	00102	PROMPT CARE					1.02
1.03	00103	WALNUT CLINIC					1.03
1.04	00104	HENRY CLINIC					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	849	0	0	4.00
5.01	00590	BUSINESS OFFICE	0	4,436	0	0	5.01
5.02	00591	A&G HOSPITAL-ONLY	0	8,865	0	0	5.02
5.03	00592	A&G SHARED	0	17,265	0	0	5.03
7.00	00700	OPERATION OF PLANT	0	69,096	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	42	7.03
7.04	00704	HENRY CLINIC PLANT OP	0	0	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	908	0	0	8.00
9.00	00900	HOUSEKEEPING	0	1,888	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	5,688	0	0	10.00
11.00	01100	CAFETERIA	0	2,827	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,041	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,029	0	0	14.00
15.00	01500	PHARMACY	0	2,157	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,612	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	688	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	22,387	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,932	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	21,912	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	198	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,084	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	377	0	0	55.00
56.00	05600	RADIOISOTOPE	0	973	0	0	56.00
57.00	05700	CT SCAN	0	1,105	0	0	57.00
58.00	05800	MRI	0	1,269	0	0	58.00
60.00	06000	LABORATORY	0	4,428	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,283	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,792	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	87	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	84	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	382	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	1,706	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	1,156	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	11,186	0	0	90.00
90.01	04950	SLEEP LAB	0	767	0	0	90.01
90.02	09001	GENERAL SURGERY CL	0	3,249	0	0	90.02
90.03	09002	PM PAIN CLINIC	0	1,513	0	0	90.03
91.00	09100	EMERGENCY	0	9,884	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	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	222,103	0	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	730	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	540	0	0	192.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/24/2022 11:43 am

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	
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	0	0	0	267	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	3,365	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	18,856	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	245,594	0	0	315	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	BUSINESS OFFICE	
			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						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	849	849		4.00
5.01	00590	BUSINESS OFFICE	0	0	4,436	52	4,488	5.01
5.02	00591	A&G HOSPITAL-ONLY	0	50,409	59,274	5	0	5.02
5.03	00592	A&G SHARED	0	74,888	92,153	39	0	5.03
7.00	00700	OPERATION OF PLANT	0	49,287	118,383	20	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	42	0	0	7.03
7.04	00704	HENRY CLINIC PLANT OP	196	0	196	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	908	2	0	8.00
9.00	00900	HOUSEKEEPING	0	756	2,644	16	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	30	0	30	0	0	9.04
10.00	01000	DIETARY	0	3,111	8,799	13	0	10.00
11.00	01100	CAFETERIA	0	0	2,827	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,041	19	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,802	4,831	7	0	14.00
15.00	01500	PHARMACY	0	2,847	5,004	16	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,025	5,637	17	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	688	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	9,691	32,078	76	158	30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,287	12,219	3	29	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	26,695	48,607	50	524	50.00
53.00	05300	ANESTHESIOLOGY	0	17,126	17,324	0	50	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	79,600	83,684	40	194	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	377	11	142	55.00
56.00	05600	RADIOISOTOPE	0	0	973	0	35	56.00
57.00	05700	CT SCAN	0	264	1,369	0	610	57.00
58.00	05800	MRI	0	767	2,036	4	138	58.00
60.00	06000	LABORATORY	0	11,607	16,035	36	786	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	15	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,948	5,231	22	48	65.00
66.00	06600	PHYSICAL THERAPY	0	2,067	7,859	30	183	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	87	0	2	68.00
69.00	06900	ELECTROCARDIOLOGY	0	766	850	0	49	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	382	0	1	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	42	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	36	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	405	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	1,706	0	34	76.01
76.97	07697	CARDIAC REHABILITATION	0	1,463	2,619	11	25	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	25,711	25,711	135	174	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	317	317	26	60	88.01
90.00	09000	CLINIC	0	6,018	17,204	88	128	90.00
90.01	04950	SLEEP LAB	0	361	1,128	4	37	90.01
90.02	09001	GENERAL SURGERY CL	0	0	3,249	26	2	90.02
90.03	09002	PM PAIN CLINIC	0	2,042	3,555	0	2	90.03
91.00	09100	EMERGENCY	0	11,926	21,810	69	579	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	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	226	392,781	615,158	837	4,488	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	730	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	540	0	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/24/2022 11:43 am

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	
194.00	07956	WALNUT & HENRY CLINICS	530	0	797	12	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	3,365	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	18,856	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	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	756	392,781	639,446	849	4,488	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/24/2022 11:43 am

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	59,279				5.02
5.03	00592	A&G SHARED	8,058	100,250			5.03
7.00	00700	OPERATION OF PLANT	4,258	8,334	130,995		7.00
7.01	00701	PERRY PLAZA PLANT OP	0	0	0	0	7.01
7.02	00702	PROMPT CARE PLANT OP	22	44	0	0	7.02
7.03	00703	WALNUT CLINIC PLANT OP	14	27	0	0	7.03
7.04	00704	HENRY CLINIC PLANT OP	14	27	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	211	412	820	0	8.00
9.00	00900	HOUSEKEEPING	822	1,610	1,704	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	0	9.03
9.04	00904	HENRY CLINIC HSKPING	0	0	0	0	9.04
10.00	01000	DIETARY	1,045	2,045	5,136	0	10.00
11.00	01100	CAFETERIA	16	32	2,553	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,201	2,351	1,842	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	490	960	1,832	0	14.00
15.00	01500	PHARMACY	1,061	2,076	1,947	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	755	1,478	4,164	0	16.00
17.00	01700	SOCIAL SERVICE	396	775	621	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,291	6,440	20,214	0	30.00
31.00	03100	INTENSIVE CARE UNIT	275	538	3,550	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,987	7,804	19,784	0	50.00
53.00	05300	ANESTHESIOLOGY	237	464	179	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,784	5,448	3,687	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	855	1,674	340	0	55.00
56.00	05600	RADIOISOTOPE	323	631	878	0	56.00
57.00	05700	CT SCAN	1,570	3,073	997	0	57.00
58.00	05800	MRI	597	1,168	1,146	0	58.00
60.00	06000	LABORATORY	4,479	8,765	3,998	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	150	293	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	906	1,773	2,061	0	65.00
66.00	06600	PHYSICAL THERAPY	1,484	2,904	5,230	0	66.00
68.00	06800	SPEECH PATHOLOGY	13	26	79	0	68.00
69.00	06900	ELECTROCARDIOLOGY	114	223	76	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5	10	345	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	294	575	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	763	1,493	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,790	5,461	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	693	1,356	1,540	0	76.01
76.97	07697	CARDIAC REHABILITATION	441	863	1,044	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	5,874	11,502	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,194	2,337	0	0	88.01
90.00	09000	CLINIC	1,917	3,751	10,100	0	90.00
90.01	04950	SLEEP LAB	218	426	693	0	90.01
90.02	09001	GENERAL SURGERY CL	307	601	2,934	0	90.02
90.03	09002	PM PAIN CLINIC	65	127	1,366	0	90.03
91.00	09100	EMERGENCY	4,572	8,948	8,924	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58,561	98,845	109,784	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	105	206	659	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3	6	488	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	480	940	0	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	20	38	3,039	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	194.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/24/2022 11:43 am

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	
194.03	07953	MOB LEASED SPACE	110	215	17,025	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)	59,279	100,250	130,995	0	66	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/24/2022 11:43 am

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	83				7.03
7.04	00704	HENRY CLINIC PLANT OP	0	237			7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	2,353		8.00
9.00	00900	HOUSEKEEPING	0	0	0	6,796	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	96	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	172	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	17	90	14.00
15.00	01500	PHARMACY	0	0	0	62	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	21	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	110	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	520	1,398	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	68	151	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	687	1,487	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	111	365	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	88	0	55.00
56.00	05600	RADIOISOTOPE	0	0	14	0	56.00
57.00	05700	CT SCAN	0	0	88	69	57.00
58.00	05800	MRI	0	0	63	48	58.00
60.00	06000	LABORATORY	0	0	0	234	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	110	65.00
66.00	06600	PHYSICAL THERAPY	0	0	67	172	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
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	83	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	34	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	10	1,088	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	4	28	88.01
90.00	09000	CLINIC	0	0	6	124	90.00
90.01	04950	SLEEP LAB	0	0	0	110	90.01
90.02	09001	GENERAL SURGERY CL	0	0	2	0	90.02
90.03	09002	PM PAIN CLINIC	0	0	0	138	90.03
91.00	09100	EMERGENCY	0	0	579	585	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)	2	13	2,324	6,775	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	81	224	29	21	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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

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

 Worksheet B
 Part II
 Date/Time Prepared:
 2/24/2022 11:43 am

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	
194.03	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)	83	237	2,353	6,796	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/24/2022 11:43 am

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	3				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	17,134	10.00
11.00	01100	CAFETERIA	0	0	0	12,372	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	517	14.00
15.00	01500	PHARMACY	0	0	0	461	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,069	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	4,436	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	316	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	1,741	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,690	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	365	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	149	58.00
60.00	06000	LABORATORY	0	0	0	1,809	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	911	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	979	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	12	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	308	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	3	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	1,122	90.00
90.01	04950	SLEEP LAB	0	0	0	163	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	377	90.02
90.03	09002	PM PAIN CLINIC	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	2,559	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)	3	0	0	17,134	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	8	43	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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description			PROMPT CARE HSKPING	WALNUT CLINIC HSKPING	HENRY CLINIC HSKPING	DIETARY	CAFETERIA	
			9.02	9.03	9.04	10.00	11.00	
194.03	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)	3	8	43	17,134	17,800	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/24/2022 11:43 am

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	8,131					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	181	8,925				14.00
15.00	01500	PHARMACY	0	83	10,710			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	13,141		16.00
17.00	01700	SOCIAL SERVICE	0	1	0	0	2,601	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,965	332	0	462	2,482	30.00
31.00	03100	INTENSIVE CARE UNIT	101	80	0	85	119	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,746	1,178	0	1,534	0	50.00
53.00	05300	ANESTHESIOLOGY	0	103	0	145	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18	0	568	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	124	0	416	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	102	0	56.00
57.00	05700	CT SCAN	0	166	0	1,785	0	57.00
58.00	05800	MRI	0	34	0	403	0	58.00
60.00	06000	LABORATORY	0	446	0	2,307	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	44	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	141	0	65.00
66.00	06600	PHYSICAL THERAPY	0	80	0	536	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	5	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2	0	144	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	759	0	122	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,545	0	107	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	10,710	1,186	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	0	101	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	13	0	73	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	207	0	510	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	192	0	174	0	88.01
90.00	09000	CLINIC	594	1,533	0	374	0	90.00
90.01	04950	SLEEP LAB	0	27	0	108	0	90.01
90.02	09001	GENERAL SURGERY CL	0	20	0	6	0	90.02
90.03	09002	PM PAIN CLINIC	0	140	0	5	0	90.03
91.00	09100	EMERGENCY	2,544	714	0	1,694	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,131	8,797	10,710	13,141	2,601	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	59	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	69	0	0	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	0	194.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	0	0	0	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					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,131	8,925	10,710	13,141	2,601

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	PERRY PLAZA B&F				1.01
1.02	00102	PROMPT CARE				1.02
1.03	00103	WALNUT CLINIC				1.03
1.04	00104	HENRY CLINIC				1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	BUSINESS OFFICE				5.01
5.02	00591	A&G HOSPITAL-ONLY				5.02
5.03	00592	A&G SHARED				5.03
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	PERRY PLAZA PLANT OP				7.01
7.02	00702	PROMPT CARE PLANT OP				7.02
7.03	00703	WALNUT CLINIC PLANT OP				7.03
7.04	00704	HENRY CLINIC PLANT OP				7.04
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
9.01	00901	PERRY PLAZA HSKPING				9.01
9.02	00902	PROMPT CARE HSKPING				9.02
9.03	00903	WALNUT CLINIC HSKPING				9.03
9.04	00904	HENRY CLINIC HSKPING				9.04
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	77,809	0	77,809	30.00
31.00	03100	INTENSIVE CARE UNIT	17,635	0	17,635	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	89,129	0	89,129	50.00
53.00	05300	ANESTHESIOLOGY	18,502	0	18,502	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,598	0	98,598	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,392	0	4,392	55.00
56.00	05600	RADIOISOTOPE	2,956	0	2,956	56.00
57.00	05700	CT SCAN	9,727	0	9,727	57.00
58.00	05800	MRI	5,786	0	5,786	58.00
60.00	06000	LABORATORY	38,895	0	38,895	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	502	0	502	63.00
65.00	06500	RESPIRATORY THERAPY	11,203	0	11,203	65.00
66.00	06600	PHYSICAL THERAPY	19,524	0	19,524	66.00
68.00	06800	SPEECH PATHOLOGY	224	0	224	68.00
69.00	06900	ELECTROCARDIOLOGY	1,463	0	1,463	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	747	0	747	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,792	0	1,792	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,944	0	4,944	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,552	0	20,552	73.00
76.00	03140	CARDIOLOGY	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	5,513	0	5,513	76.01
76.97	07697	CARDIAC REHABILITATION	5,431	0	5,431	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	45,211	0	45,211	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,389	0	4,389	88.01
90.00	09000	CLINIC	36,941	0	36,941	90.00
90.01	04950	SLEEP LAB	2,914	0	2,914	90.01
90.02	09001	GENERAL SURGERY CL	7,524	0	7,524	90.02
90.03	09002	PM PAIN CLINIC	5,398	0	5,398	90.03
91.00	09100	EMERGENCY	53,577	0	53,577	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	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	591,278	0	591,278	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,759	0	1,759	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,037	0	1,037	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	192.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
194.00	07956	WALNUT & HENRY CLINICS	2,704	0	2,704		194.00
194.01	07951	HOSPITAL LEASED SPACE	6,462	0	6,462		194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0		194.02
194.03	07953	MOB LEASED SPACE	36,206	0	36,206		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	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	639,446	0	639,446		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1337

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

Worksheet B-1

Date/Time Prepared:
2/24/2022 11:43 am

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	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	186,314					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	3,070	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	16,623	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	0	0	0	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	4,394	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	66	0	0	0	0	68.00
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	1,492	0	0	88.01
90.00	09000	CLINIC	8,486	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	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)	168,492	0	2,185	124	919	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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1337

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

Worksheet B-1

Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	PERRY PLAZA B&F (PERRY PLAZ A SQ FT)	PROMPT CARE (PROMPT CAR E SQ FT)	WALNUT CLINIC (WALNUT CLI NIC SQ FT)	HENRY CLINIC (HENRY CLIN IC SQ FT)	
			1.00	1.01	1.02	1.03	1.04	
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	0	0	691	2,151	194.00
194.01	07951	HOSPITAL LEASED SPACE	2,553	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)	245,594	0	0	315	756	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.318173	0.000000	0.000000	0.386503	0.246254	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 07/01/2021
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description		CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	BUSINESS OFFICE (GROSS REVE NUE)	Reconciliation	A&G HOSPITAL-ONLY (ACCUM. COST)	
		MVBLE EQUIP (DOLLAR VALUE)					
		2.00	4.00	5.01	5A.02	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	PERRY PLAZA B&F					1.01
1.02	00102	PROMPT CARE					1.02
1.03	00103	WALNUT CLINIC					1.03
1.04	00104	HENRY CLINIC					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	355,355				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,816,388			4.00
5.01	00590	BUSINESS OFFICE	0	235,532	25,681,016		5.01
5.02	00591	A&G HOSPITAL-ONLY	45,606	22,991	0	-370,696	5.02
5.03	00592	A&G SHARED	67,752	175,025	0	0	5.03
7.00	00700	OPERATION OF PLANT	44,591	88,254	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	0	7.03
7.04	00704	HENRY CLINIC PLANT OP	0	0	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,141	0	0	8.00
9.00	00900	HOUSEKEEPING	684	72,001	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	0	9.03
9.04	00904	HENRY CLINIC HSKPING	0	0	0	0	9.04
10.00	01000	DIETARY	2,815	57,248	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	83,764	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,535	29,484	0	0	14.00
15.00	01500	PHARMACY	2,576	71,385	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	927	76,396	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,768	340,841	902,155	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7,497	14,388	165,707	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	24,151	227,228	2,995,837	0	50.00
53.00	05300	ANESTHESIOLOGY	15,494	0	283,146	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,014	179,930	1,109,221	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	51,715	812,519	0	55.00
56.00	05600	RADIOISOTOPE	0	0	198,896	0	56.00
57.00	05700	CT SCAN	239	0	3,486,958	0	57.00
58.00	05800	MRI	694	19,730	786,281	0	58.00
60.00	06000	LABORATORY	10,501	161,237	4,527,443	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	85,373	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,667	98,105	275,283	0	65.00
66.00	06600	PHYSICAL THERAPY	1,870	133,884	1,046,232	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	1,347	10,200	0	68.00
69.00	06900	ELECTROCARDIOLOGY	693	265	281,798	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	7,266	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	237,309	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	208,103	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,316,422	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	196,767	0	76.01
76.97	07697	CARDIAC REHABILITATION	1,324	49,219	141,690	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	23,261	607,005	995,552	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	287	118,436	340,515	0	88.01
90.00	09000	CLINIC	5,445	394,908	729,666	0	90.00
90.01	04950	SLEEP LAB	327	16,829	210,543	0	90.01
90.02	09001	GENERAL SURGERY CL	0	115,208	11,126	0	90.02
90.03	09002	PM PAIN CLINIC	1,847	0	9,487	0	90.03
91.00	09100	EMERGENCY	10,790	311,129	3,309,521	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	355,355	3,760,625	25,681,016	-370,696	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1337

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

Worksheet B-1

Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description			CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	BUSINESS OFFICE (GROSS REVE NUE)	Reconciliation	A&G HOSPITAL-ONLY (ACCUM. COST)	
			MVBLE EQUIP (DOLLAR VALUE)					
			2.00	4.00	5.01	5A.02	5.02	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	540	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	55,763	0	0	82,398	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	3,365	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	18,856	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)	392,781	271,715	1,663,656		370,696	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.105320	0.071197	0.064782		0.036454	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		849	4,488		59,279	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000222	0.000175		0.005829	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 07/01/2021
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description		Reconciliation	A&G SHARED (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	PERRY PLAZA PLANT OP (PERRY PLAZ A SQ FT)	PROMPT CARE PLANT OP (PROMPT CAR E 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	-1,432,171	9,107,434			5.03
7.00	00700	OPERATION OF PLANT	0	757,134	110,064		7.00
7.01	00701	PERRY PLAZA PLANT OP	0	0	0	0	7.01
7.02	00702	PROMPT CARE PLANT OP	0	3,970	0	0	7.02
7.03	00703	WALNUT CLINIC PLANT OP	0	2,496	0	0	7.03
7.04	00704	HENRY CLINIC PLANT OP	0	2,450	0	0	7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	37,458	689	0	8.00
9.00	00900	HOUSEKEEPING	0	146,234	1,432	0	9.00
9.01	00901	PERRY PLAZA HSKPING	0	0	0	0	9.01
9.02	00902	PROMPT CARE HSKPING	0	0	0	80	9.02
9.03	00903	WALNUT CLINIC HSKPING	0	6	0	0	9.03
9.04	00904	HENRY CLINIC HSKPING	0	31	0	0	9.04
10.00	01000	DIETARY	0	185,760	4,315	0	10.00
11.00	01100	CAFETERIA	0	2,930	2,145	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	213,576	1,548	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	87,190	1,539	0	14.00
15.00	01500	PHARMACY	0	188,583	1,636	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	134,319	3,499	0	16.00
17.00	01700	SOCIAL SERVICE	0	70,388	522	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	585,096	16,983	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	48,853	2,983	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	708,978	16,623	0	50.00
53.00	05300	ANESTHESIOLOGY	0	42,123	150	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	494,949	3,098	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	152,048	286	0	55.00
56.00	05600	RADIOISOTOPE	0	57,360	738	0	56.00
57.00	05700	CT SCAN	0	279,152	838	0	57.00
58.00	05800	MRI	0	106,133	963	0	58.00
60.00	06000	LABORATORY	0	796,347	3,359	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	26,661	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	161,116	1,732	0	65.00
66.00	06600	PHYSICAL THERAPY	0	263,829	4,394	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	2,388	66	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	20,304	64	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	884	290	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	52,214	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	135,660	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	496,119	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	123,206	1,294	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	78,403	877	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,044,408	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	212,357	0	0	88.01
90.00	09000	CLINIC	0	340,788	8,486	0	90.00
90.01	04950	SLEEP LAB	0	38,679	582	0	90.01
90.02	09001	GENERAL SURGERY CL	0	54,623	2,465	0	90.02
90.03	09002	PM PAIN CLINIC	0	11,568	1,148	0	90.03
91.00	09100	EMERGENCY	0	812,939	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	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)	-1,432,171	8,979,710	92,242	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,731	554	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	560	410	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	85,402	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1337

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

Worksheet B-1

Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description			Reconciliation	A&G SHARED (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	PERRY PLAZA PLANT OP (PERRY PLAZ A SQ FT)	PROMPT CARE PLANT OP (PROMPT CAR E SQ FT)	
			5A.03	5.03	7.00	7.01	7.02	
194.01	07951	HOSPITAL LEASED SPACE	0	3,488	2,553	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	19,543	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)		1,432,171	876,196	0	4,594	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.157253	7.960786	0.000000	2.522790	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		100,250	130,995	0	66	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.011007	1.190171	0.000000	0.036244	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 07/01/2021
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 11:43 am

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	2,273			7.04
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	35,398		8.00
9.00	00900	HOUSEKEEPING	0	0	0	987	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	14	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	25	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	254	13	14.00
15.00	01500	PHARMACY	0	0	0	9	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	3	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	16	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	7,829	203	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	1,024	22	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	10,338	216	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,667	53	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	1,326	0	55.00
56.00	05600	RADIOISOTOPE	0	0	211	0	56.00
57.00	05700	CT SCAN	0	0	1,317	10	57.00
58.00	05800	MRI	0	0	944	7	58.00
60.00	06000	LABORATORY	0	0	0	34	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	16	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,005	25	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
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	12	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	5	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	153	158	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	64	4	88.01
90.00	09000	CLINIC	0	0	89	18	90.00
90.01	04950	SLEEP LAB	0	0	0	16	90.01
90.02	09001	GENERAL SURGERY CL	0	0	37	0	90.02
90.03	09002	PM PAIN CLINIC	0	0	0	20	90.03
91.00	09100	EMERGENCY	0	0	8,704	85	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)	15	122	34,962	984	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	691	2,151	436	3	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1337

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

Worksheet B-1

Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description			WALNUT CLINIC PLANT OP (WALNUT CLINIC SQ FT)	HENRY CLINIC PLANT OP (HENRY CLINIC SQ FT)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	PERRY PLAZA HSPKING (PERRY PLAZA SQ FT)	
			7.03	7.04	8.00	9.00	9.01	
194.01	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)	2,889	2,835	48,833	180,630	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.092068	1.247250	1.379541	183.009119	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	83	237	2,353	6,796	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.117564	0.104267	0.066473	6.885512	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 07/01/2021
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 11:43 am

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 SERVED)	
		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	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	1,741				9.02
9.03	00903	WALNUT CLINIC HSKPING	0	691			9.03
9.04	00904	HENRY CLINIC HSKPING	0	0	2,151		9.04
10.00	01000	DIETARY	0	0	0	6,563	10.00
11.00	01100	CAFETERIA	0	0	0	4,739	11,806
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	335
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	343
15.00	01500	PHARMACY	0	0	0	0	306
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	709
17.00	01700	SOCIAL SERVICE	0	0	0	4	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	1,699	1,962
31.00	03100	INTENSIVE CARE UNIT	0	0	0	121	67
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	1,155
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	249	0	0	0	1,121
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	242
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	99
60.00	06000	LABORATORY	0	0	0	0	1,200
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	604
66.00	06600	PHYSICAL THERAPY	0	0	0	0	649
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	8
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	3
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03140	CARDIOLOGY	0	0	0	0	0
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	204
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
88.01	08801	RURAL HEALTH CLINIC II	1,492	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	744
90.01	04950	SLEEP LAB	0	0	0	0	108
90.02	09001	GENERAL SURGERY CL	0	0	0	0	250
90.03	09002	PM PAIN CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	1,697
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
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,741	0	0	6,563	11,806
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0
194.00	07956	WALNUT & HENRY CLINICS	0	691	2,151	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1337

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

Worksheet B-1

Date/Time Prepared:
2/24/2022 11:43 am

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 SERVED)	
			9.02	9.03	9.04	10.00	11.00	
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)	202	68	188	251,884	202,346	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.116025	0.098408	0.087401	38.379400	17.139251	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3	8	43	17,134	17,800	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001723	0.011577	0.019991	2.610696	1.507708	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 07/01/2021
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/24/2022 11:43 am

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	
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	28,237					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	629	411,570				14.00
15.00	01500	PHARMACY	0	3,805	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	25,681,016		16.00
17.00	01700	SOCIAL SERVICE	0	34	0	0	371	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,296	15,317	0	902,155	354	30.00
31.00	03100	INTENSIVE CARE UNIT	351	3,695	0	165,707	17	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,064	54,315	0	2,995,837	0	50.00
53.00	05300	ANESTHESIOLOGY	0	4,732	0	283,146	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	835	0	1,109,221	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	5,708	0	812,519	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	198,896	0	56.00
57.00	05700	CT SCAN	0	7,645	0	3,486,958	0	57.00
58.00	05800	MRI	0	1,568	0	786,281	0	58.00
60.00	06000	LABORATORY	0	20,586	0	4,527,443	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	85,373	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	275,283	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,685	0	1,046,232	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	10,200	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	81	0	281,798	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	7,266	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	35,005	0	237,309	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	117,408	0	208,103	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	2,316,422	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	0	196,767	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	591	0	141,690	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	9,540	0	995,552	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	8,872	0	340,515	0	88.01
90.00	09000	CLINIC	2,063	70,684	0	729,666	0	90.00
90.01	04950	SLEEP LAB	0	1,251	0	210,543	0	90.01
90.02	09001	GENERAL SURGERY CL	0	907	0	11,126	0	90.02
90.03	09002	PM PAIN CLINIC	0	6,475	0	9,487	0	90.03
91.00	09100	EMERGENCY	8,834	32,908	0	3,309,521	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,237	405,647	100	25,681,016	371	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,743	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1337

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

Worksheet B-1

Date/Time Prepared:
2/24/2022 11:43 am

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	
194.00	07956	WALNUT & HENRY CLINICS	0	3,180	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
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)	269,801	127,771	239,335	195,997	88,706	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.554875	0.310448	2,393.350000	0.007632	239.099730	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,131	8,925	10,710	13,141	2,601	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.287956	0.021685	107.100000	0.000512	7.010782	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 07/01/2021
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/24/2022 11:43 am

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,153,744		1,153,744	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	101,344		101,344	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,124,058		1,124,058	0	0	50.00
53.00	05300	ANESTHESIOLOGY	53,571		53,571	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	638,038		638,038	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	192,185		192,185	0	0	55.00
56.00	05600	RADIOISOTOPE	74,064		74,064	0	0	56.00
57.00	05700	CT SCAN	362,352		362,352	0	0	57.00
58.00	05800	MRI	141,257		141,257	0	0	58.00
60.00	06000	LABORATORY	1,016,048		1,016,048	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	31,506		31,506	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	215,621	0	215,621	0	0	65.00
66.00	06600	PHYSICAL THERAPY	366,510	0	366,510	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	3,504	0	3,504	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	26,233		26,233	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,387		3,387	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	73,103		73,103	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	195,031		195,031	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	831,149		831,149	0	0	73.00
76.00	03140	CARDIOLOGY	0		0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	156,580		156,580	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	103,389		103,389	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,248,329		1,248,329	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	255,861		255,861	0	0	88.01
90.00	09000	CLINIC	525,327		525,327	0	0	90.00
90.01	04950	SLEEP LAB	56,168		56,168	0	0	90.01
90.02	09001	GENERAL SURGERY CL	87,539		87,539	0	0	90.02
90.03	09002	PM PAIN CLINIC	28,268		28,268	0	0	90.03
91.00	09100	EMERGENCY	1,176,997		1,176,997	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	446,243		446,243	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	10,687,406	0	10,687,406	0	0	200.00
201.00		Less Observation Beds	446,243		446,243			201.00
202.00		Total (see instructions)	10,241,163	0	10,241,163	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/24/2022 11:43 am

			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	580,025		580,025		30.00
31.00	03100	INTENSIVE CARE UNIT	165,707		165,707		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	367,419	2,628,418	2,995,837	0.375207	0.000000
53.00	05300	ANESTHESIOLOGY	41,921	241,225	283,146	0.189199	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,043	1,058,178	1,109,221	0.575213	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	12,008	800,511	812,519	0.236530	0.000000
56.00	05600	RADIOISOTOPE	0	198,896	198,896	0.372376	0.000000
57.00	05700	CT SCAN	123,463	3,363,495	3,486,958	0.103916	0.000000
58.00	05800	MRI	20,737	765,544	786,281	0.179652	0.000000
60.00	06000	LABORATORY	280,149	4,247,294	4,527,443	0.224420	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,836	77,537	85,373	0.369039	0.000000
65.00	06500	RESPIRATORY THERAPY	124,536	150,747	275,283	0.783270	0.000000
66.00	06600	PHYSICAL THERAPY	83,855	962,377	1,046,232	0.350314	0.000000
68.00	06800	SPEECH PATHOLOGY	0	10,200	10,200	0.343529	0.000000
69.00	06900	ELECTROCARDIOLOGY	8,448	273,350	281,798	0.093092	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,266	7,266	0.466144	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	119,901	117,408	237,309	0.308050	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	87,607	120,496	208,103	0.937185	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	339,391	1,977,031	2,316,422	0.358807	0.000000
76.00	03140	CARDIOLOGY	0	0	0	0.000000	0.000000
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	196,767	196,767	0.795764	0.000000
76.97	07697	CARDIAC REHABILITATION	0	141,690	141,690	0.729685	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,658	993,894	995,552		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	340,515	340,515		88.01
90.00	09000	CLINIC	1,137	728,529	729,666	0.719955	0.000000
90.01	04950	SLEEP LAB	0	210,543	210,543	0.266777	0.000000
90.02	09001	GENERAL SURGERY CL	1,108	10,018	11,126	7.867967	0.000000
90.03	09002	PM PAIN CLINIC	0	9,487	9,487	2.979656	0.000000
91.00	09100	EMERGENCY	49,903	3,259,618	3,309,521	0.355640	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,000	321,130	322,130	1.385289	0.000000
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	2,468,852	23,212,164	25,681,016		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	2,468,852	23,212,164	25,681,016		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/24/2022 11:43 am

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
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
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

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/24/2022 11:43 am

			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	580,025		580,025			30.00
31.00	03100	INTENSIVE CARE UNIT	165,707		165,707			31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	367,419	2,628,418	2,995,837	0.375207	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	41,921	241,225	283,146	0.189199	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,043	1,058,178	1,109,221	0.575213	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,008	800,511	812,519	0.236530	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	198,896	198,896	0.372376	0.000000	56.00
57.00	05700	CT SCAN	123,463	3,363,495	3,486,958	0.103916	0.000000	57.00
58.00	05800	MRI	20,737	765,544	786,281	0.179652	0.000000	58.00
60.00	06000	LABORATORY	280,149	4,247,294	4,527,443	0.224420	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,836	77,537	85,373	0.369039	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	124,536	150,747	275,283	0.783270	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	83,855	962,377	1,046,232	0.350314	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	10,200	10,200	0.343529	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	8,448	273,350	281,798	0.093092	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,266	7,266	0.466144	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	119,901	117,408	237,309	0.308050	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	87,607	120,496	208,103	0.937185	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	339,391	1,977,031	2,316,422	0.358807	0.000000	73.00
76.00	03140	CARDIOLOGY	0	0	0	0.000000	0.000000	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	196,767	196,767	0.795764	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	141,690	141,690	0.729685	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,658	993,894	995,552	1.253906	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	340,515	340,515	0.751394	0.000000	88.01
90.00	09000	CLINIC	1,137	728,529	729,666	0.719955	0.000000	90.00
90.01	04950	SLEEP LAB	0	210,543	210,543	0.266777	0.000000	90.01
90.02	09001	GENERAL SURGERY CL	1,108	10,018	11,126	7.867967	0.000000	90.02
90.03	09002	PM PAIN CLINIC	0	9,487	9,487	2.979656	0.000000	90.03
91.00	09100	EMERGENCY	49,903	3,259,618	3,309,521	0.355640	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,000	321,130	322,130	1.385289	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	2,468,852	23,212,164	25,681,016			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,468,852	23,212,164	25,681,016			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-1337	Period: From 07/01/2021 To 09/30/2021	Worksheet C Part I Date/Time Prepared: 2/24/2022 11:43 am
				Title XIX	Hospital	Cost
Cost Center Description			PPS Inpatient Ratio			
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		30.00		
31.00	03100	INTENSIVE CARE UNIT		31.00		
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		
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00		
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 07/01/2021
To 09/30/2021Worksheet D
Part II
Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description		Title XVIII		Hospital		Cost	
		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	89,129	2,995,837	0.029751	231,362	6,883 50.00
53.00	05300	ANESTHESIOLOGY	18,502	283,146	0.065344	19,323	1,263 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,598	1,109,221	0.088889	19,175	1,704 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,392	812,519	0.005405	11,947	65 55.00
56.00	05600	RADIOISOTOPE	2,956	198,896	0.014862	0	0 56.00
57.00	05700	CT SCAN	9,727	3,486,958	0.002790	24,764	69 57.00
58.00	05800	MRI	5,786	786,281	0.007359	12,633	93 58.00
60.00	06000	LABORATORY	38,895	4,527,443	0.008591	109,952	945 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	502	85,373	0.005880	5,332	31 63.00
65.00	06500	RESPIRATORY THERAPY	11,203	275,283	0.040696	26,754	1,089 65.00
66.00	06600	PHYSICAL THERAPY	19,524	1,046,232	0.018661	45,165	843 66.00
68.00	06800	SPEECH PATHOLOGY	224	10,200	0.021961	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	1,463	281,798	0.005192	2,816	15 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	747	7,266	0.102808	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,792	237,309	0.007551	40,339	305 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,944	208,103	0.023757	83,979	1,995 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,552	2,316,422	0.008872	102,367	908 73.00
76.00	03140	CARDIOLOGY	0	0	0.000000	0	0 76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	5,513	196,767	0.028018	0	0 76.01
76.97	07697	CARDIAC REHABILITATION	5,431	141,690	0.038330	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	45,211	995,552	0.045413	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	4,389	340,515	0.012889	0	0 88.01
90.00	09000	CLINIC	36,941	729,666	0.050627	755	38 90.00
90.01	04950	SLEEP LAB	2,914	210,543	0.013840	0	0 90.01
90.02	09001	GENERAL SURGERY CL	7,524	11,126	0.676254	0	0 90.02
90.03	09002	PM PAIN CLINIC	5,398	9,487	0.568989	0	0 90.03
91.00	09100	EMERGENCY	53,577	3,309,521	0.016189	28	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	30,095	322,130	0.093425	855	80 92.00
200.00		Total (lines 50 through 199)	525,929	24,935,284		737,546	16,326 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1337

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

Worksheet D
Part IV
Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description			Title XVIII		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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 07/01/2021 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/24/2022 11:43 am	
			Title XVIII		Hospital		Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,995,837	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	283,146	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,109,221	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	812,519	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	198,896	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	3,486,958	0.000000	57.00
58.00	05800	MRI	0	0	0	786,281	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	4,527,443	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	85,373	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	275,283	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,046,232	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	10,200	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	281,798	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	7,266	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	237,309	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	208,103	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,316,422	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	196,767	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	141,690	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	995,552	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	340,515	0.000000	88.01
90.00	09000	CLINIC	0	0	0	729,666	0.000000	90.00
90.01	04950	SLEEP LAB	0	0	0	210,543	0.000000	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	11,126	0.000000	90.02
90.03	09002	PM PAIN CLINIC	0	0	0	9,487	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	3,309,521	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	322,130	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	24,935,284		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description		Title XVIII			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	231,362	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	19,323	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	19,175	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	11,947	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	24,764	0	0	0	57.00
58.00	05800	MRI	0.000000	12,633	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	109,952	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	5,332	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	26,754	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	45,165	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,816	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	40,339	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	83,979	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	102,367	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	755	0	0	0	90.00
90.01	04950	SLEEP LAB	0.000000	0	0	0	0	90.01
90.02	09001	GENERAL SURGERY CL	0.000000	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	28	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	855	0	0	0	92.00
200.00		Total (lines 50 through 199)		737,546	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/24/2022 11:43 am

			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	0.375207	0	972,948	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.189199	0	85,463	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.575213	0	344,054	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.236530	0	359,617	0	0	55.00
56.00	05600	RADIOISOTOPE	0.372376	0	114,397	0	0	56.00
57.00	05700	CT SCAN	0.103916	0	1,414,031	0	0	57.00
58.00	05800	MRI	0.179652	0	220,638	0	0	58.00
60.00	06000	LABORATORY	0.224420	0	1,630,878	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.369039	0	68,568	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.783270	0	52,203	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.350314	0	392,056	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.343529	0	7,179	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.093092	0	125,964	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.466144	0	1,038	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.308050	0	47,781	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.937185	0	61,523	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.358807	0	1,060,017	0	0	73.00
76.00	03140	CARDIOLOGY	0.000000	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0.795764	0	159,646	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.729685	0	72,300	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	0.719955	0	261,427	0	0	90.00
90.01	04950	SLEEP LAB	0.266777	0	50,651	0	0	90.01
90.02	09001	GENERAL SURGERY CL	7.867967	0	3,905	0	0	90.02
90.03	09002	PM PAIN CLINIC	2.979656	0	3,564	0	0	90.03
91.00	09100	EMERGENCY	0.355640	0	1,001,977	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.385289	0	167,447	0	0	92.00
200.00		Subtotal (see instructions)		0	8,679,272	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	8,679,272	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/24/2022 11:43 am

			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	365,057	0		50.00
53.00	05300	ANESTHESIOLOGY	16,170	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	197,904	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	85,060	0		55.00
56.00	05600	RADIOISOTOPE	42,599	0		56.00
57.00	05700	CT SCAN	146,940	0		57.00
58.00	05800	MRI	39,638	0		58.00
60.00	06000	LABORATORY	366,002	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	25,304	0		63.00
65.00	06500	RESPIRATORY THERAPY	40,889	0		65.00
66.00	06600	PHYSICAL THERAPY	137,343	0		66.00
68.00	06800	SPEECH PATHOLOGY	2,466	0		68.00
69.00	06900	ELECTROCARDIOLOGY	11,726	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	484	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,719	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	57,658	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	380,342	0		73.00
76.00	03140	CARDIOLOGY	0	0		76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	127,041	0		76.01
76.97	07697	CARDIAC REHABILITATION	52,756	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	188,216	0		90.00
90.01	04950	SLEEP LAB	13,513	0		90.01
90.02	09001	GENERAL SURGERY CL	30,724	0		90.02
90.03	09002	PM PAIN CLINIC	10,619	0		90.03
91.00	09100	EMERGENCY	356,343	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	231,962	0		92.00
200.00		Subtotal (see instructions)	2,941,475	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,941,475	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1337	Period: From 07/01/2021 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/24/2022 11:43 am	
Cost Center Description		Title XVIII	Hospital	Cost	
				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			605	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			588	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)			354	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			17	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			161	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)			11	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				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			174.80	20.00
21.00	Total general inpatient routine service cost (see instructions)			1,153,744	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)			32,419	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,121,325	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,121,325	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,907.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			307,029	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)			307,029	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1337

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

Worksheet D-1

Date/Time Prepared:

2/24/2022 11:43 am

Cost Center Description		Title XVIII		Hospital		Cost	
		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	101,344	22	4,606.55	13	59,885	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)					302,445	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					669,359	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)					20,977	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					20,977	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)					234	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,907.02	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					446,243	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1337

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

Worksheet D-1

Date/Time Prepared:
2/24/2022 11:43 am

		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	77,809	1,153,744	0.067440	446,243	30,095
91.00	Nursing Program cost	0	1,153,744	0.000000	446,243	0
92.00	Allied health cost	0	1,153,744	0.000000	446,243	0
93.00	All other Medical Education	0	1,153,744	0.000000	446,243	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1337	Period: From 07/01/2021 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/24/2022 11:43 am	
		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		265,652		30.00
31.00	03100 INTENSIVE CARE UNIT		42,338		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.375207	231,362	86,809	50.00
53.00	05300 ANESTHESIOLOGY	0.189199	19,323	3,656	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.575213	19,175	11,030	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.236530	11,947	2,826	55.00
56.00	05600 RADIOISOTOPE	0.372376	0	0	56.00
57.00	05700 CT SCAN	0.103916	24,764	2,573	57.00
58.00	05800 MRI	0.179652	12,633	2,270	58.00
60.00	06000 LABORATORY	0.224420	109,952	24,675	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.369039	5,332	1,968	63.00
65.00	06500 RESPIRATORY THERAPY	0.783270	26,754	20,956	65.00
66.00	06600 PHYSICAL THERAPY	0.350314	45,165	15,822	66.00
68.00	06800 SPEECH PATHOLOGY	0.343529	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.093092	2,816	262	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.466144	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.308050	40,339	12,426	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.937185	83,979	78,704	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.358807	102,367	36,730	73.00
76.00	03140 CARDIOLOGY	0.000000	0	0	76.00
76.01	03950 SENIOR BEHAVIORAL WELLNESS	0.795764	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.729685	0	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	0.719955	755	544	90.00
90.01	04950 SLEEP LAB	0.266777	0	0	90.01
90.02	09001 GENERAL SURGERY CL	7.867967	0	0	90.02
90.03	09002 PM PAIN CLINIC	2.979656	0	0	90.03
91.00	09100 EMERGENCY	0.355640	28	10	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.385289	855	1,184	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		737,546	302,445	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)		737,546		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1337 Component CCN: 14-Z337	Period: From 07/01/2021 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/24/2022 11:43 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		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	0.375207	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.189199	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.575213	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.236530	0	0	55.00
56.00	05600 RADIOISOTOPE	0.372376	0	0	56.00
57.00	05700 CT SCAN	0.103916	0	0	57.00
58.00	05800 MRI	0.179652	0	0	58.00
60.00	06000 LABORATORY	0.224420	3,113	699	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.369039	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.783270	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.350314	6,843	2,397	66.00
68.00	06800 SPEECH PATHOLOGY	0.343529	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.093092	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.466144	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.308050	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.937185	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.358807	5,869	2,106	73.00
76.00	03140 CARDIOLOGY	0.000000	0	0	76.00
76.01	03950 SENIOR BEHAVIORAL WELLNESS	0.795764	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.729685	0	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	0.719955	0	0	90.00
90.01	04950 SLEEP LAB	0.266777	0	0	90.01
90.02	09001 GENERAL SURGERY CL	7.867967	0	0	90.02
90.03	09002 PM PAIN CLINIC	2.979656	0	0	90.03
91.00	09100 EMERGENCY	0.355640	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.385289	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		15,825	5,202	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)		15,825		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1337	Period: From 07/01/2021 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/24/2022 11:43 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,941,475	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)		2,941,475	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)		2,970,890	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)		4,457	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,403,175	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)		1,563,258	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)		1,563,258	30.00
31.00	Primary payer payments		101	31.00
32.00	Subtotal (line 30 minus line 31)		1,563,157	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)		69,036	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		44,873	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		38,837	36.00
37.00	Subtotal (see instructions)		1,608,030	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)		1,608,030	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		1,456,429	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)		151,601	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 07/01/2021
To 09/30/2021Worksheet E-1
Part I
Date/Time Prepared:
2/24/2022 11:43 am

		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		598,538		1,456,429	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)		598,538		1,456,429	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		151,601	6.01
6.02	SETTLEMENT TO PROGRAM		4,418		0	6.02
7.00	Total Medicare program liability (see instructions)		594,120		1,608,030	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 07/01/2021
To 09/30/2021Part I
Date/Time Prepared:
2/24/2022 11:43 am

		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		25,657		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)		25,657		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		598		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		26,255		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1337 Component CCN: 14-Z337	Period: From 07/01/2021 To 09/30/2021	Worksheet E-2 Date/Time Prepared: 2/24/2022 11:43 am	
		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)		21,187	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		5,254	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		11	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		26,441	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		26,441	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		26,441	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		186	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		26,255	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		26,255	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		25,657	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)		598	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparision of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1337	Period: From 07/01/2021 To 09/30/2021	Worksheet E-3 Part V Date/Time Prepared: 2/24/2022 11:43 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		669,359	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)		669,359	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		669,359	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)		669,359	19.00
20.00	Deductibles (exclude professional component)		77,168	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		592,191	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		592,191	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		2,968	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		1,929	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		594,120	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.98	Recovery of accelerated depreciation.		0	29.98
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		594,120	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		598,538	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)		-4,418	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)			33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1337

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

Worksheet G

Date/Time Prepared:
2/24/2022 11:43 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	10,304,159	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	26,332,105	0	0	0	4.00
5.00	Other receivable	130,767	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-17,012,766	0	0	0	6.00
7.00	Inventory	476,606	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	555,730	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)	20,786,601	0	0	0	11.00
FIXED ASSETS						
12.00	Land	320,233	0	0	0	12.00
13.00	Land improvements	92,482	0	0	0	13.00
14.00	Accumulated depreciation	-5,794	0	0	0	14.00
15.00	Buildings	8,830,635	0	0	0	15.00
16.00	Accumulated depreciation	-140,455	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	1,483,931	0	0	0	19.00
20.00	Accumulated depreciation	-58,568	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	32,219	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	10,554,683	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	1,478,874	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,478,874	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	32,820,158	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	550,593	0	0	0	37.00
38.00	Salaries, wages, and fees payable	46,534	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,650,181	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,247,308	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	9,620,933	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,620,933	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,868,241	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	18,951,917				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	18,951,917	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	32,820,158	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1337

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

Worksheet G-1

Date/Time Prepared:
2/24/2022 11:43 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		18,951,917				2.00
3.00	Total (sum of line 1 and line 2)		18,951,917		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		18,951,917		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)		18,951,917		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1337

Period:
From 07/01/2021
To 09/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
2/24/2022 11:43 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	553,447		553,447	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	26,578		26,578	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	580,025		580,025	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	165,707		165,707	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	165,707		165,707	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	745,732		745,732	17.00
18.00	Ancillary services	1,668,314	17,338,430	19,006,744	18.00
19.00	Outpatient services	53,148	4,539,325	4,592,473	19.00
20.00	RURAL HEALTH CLINIC	1,658	993,894	995,552	20.00
20.01	RURAL HEALTH CLINIC II	0	340,515	340,515	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER NRCC AND PROFESSIONAL FEES	96,130	2,080,267	2,176,397	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,564,982	25,292,431	27,857,413	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		10,284,804		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		10,284,804		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1337

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

Worksheet G-3

Date/Time Prepared:
2/24/2022 11:43 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	27,857,413	1.00
2.00	Less contractual allowances and discounts on patients' accounts	17,159,437	2.00
3.00	Net patient revenues (line 1 minus line 2)	10,697,976	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	10,284,804	4.00
5.00	Net income from service to patients (line 3 minus line 4)	413,172	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	18,483,721	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	43,088	24.00
24.01	OTHER NON-OPERATING INCOME	11,936	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	18,538,745	25.00
26.00	Total (line 5 plus line 25)	18,951,917	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)	18,951,917	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1337

Period:

Worksheet M-1

Component CCN: 14-8549

From 07/01/2021
To 09/30/2021Date/Time Prepared:
2/24/2022 11:43 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	208,338	49,073	257,411	-230	257,181
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	128,160	30,187	158,347	-220	158,127
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	191,417	45,087	236,504	0	236,504
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	12,076	2,844	14,920	-155	14,765
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	539,991	127,191	667,182	-605	666,577
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	45,500	45,500	0	45,500
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	45,500	45,500	0	45,500
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	539,991	172,691	712,682	-605	712,077
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	45,210	45,210
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	45,210	45,210
FACILITY OVERHEAD						
29.00	Facility Costs	0	17,700	17,700	0	17,700
30.00	Administrative Costs	99,079	76,853	175,932	-76,670	99,262
31.00	Total Facility Overhead (sum of lines 29 and 30)	99,079	94,553	193,632	-76,670	116,962
32.00	Total facility costs (sum of lines 22, 28 and 31)	639,070	267,244	906,314	-32,065	874,249

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1337

Period:

Worksheet M-1

Component CCN: 14-8549

From 07/01/2021
To 09/30/2021Date/Time Prepared:
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				RHC I	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	257,181	1.00	
2.00	Physician Assistant	0	0	2.00	
3.00	Nurse Practitioner	0	158,127	3.00	
4.00	Visiting Nurse	0	0	4.00	
5.00	Other Nurse	0	236,504	5.00	
6.00	Clinical Psychologist	0	0	6.00	
7.00	Clinical Social Worker	0	14,765	7.00	
8.00	Laboratory Technician	0	0	8.00	
9.00	Other Facility Health Care Staff Costs	0	0	9.00	
10.00	Subtotal (sum of lines 1 through 9)	0	666,577	10.00	
11.00	Physician Services Under Agreement	0	0	11.00	
12.00	Physician Supervision Under Agreement	0	0	12.00	
13.00	Other Costs Under Agreement	0	0	13.00	
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00	
15.00	Medical Supplies	0	45,500	15.00	
16.00	Transportation (Health Care Staff)	0	0	16.00	
17.00	Depreciation-Medical Equipment	0	0	17.00	
18.00	Professional Liability Insurance	0	0	18.00	
19.00	Other Health Care Costs	0	0	19.00	
20.00	Allowable GME Costs			20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	45,500	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	712,077	22.00	
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0	23.00	
24.00	Dental	0	0	24.00	
25.00	Optometry	0	0	25.00	
25.01	Telehealth	0	45,210	25.01	
25.02	Chronic Care Management	0	0	25.02	
26.00	All other nonreimbursable costs	0	0	26.00	
27.00	Nonallowable GME costs			27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	45,210	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	0	17,700	29.00	
30.00	Administrative Costs	0	99,262	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	116,962	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	874,249	32.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1337

Period:

Worksheet M-1

Component CCN: 14-8583

From 07/01/2021
To 09/30/2021Date/Time Prepared:
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		RHC II		Cost		
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	17,936	4,458	22,394	-201	22,193 1.00
2.00	Physician Assistant	2,618	651	3,269	-149	3,120 2.00
3.00	Nurse Practitioner	41,883	10,410	52,293	-485	51,808 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	9,444	2,347	11,791	0	11,791 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	26,884	6,682	33,566	0	33,566 9.00
10.00	Subtotal (sum of lines 1 through 9)	98,765	24,548	123,313	-835	122,478 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	9,861	9,861	0	9,861 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	9,861	9,861	0	9,861 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	98,765	34,409	133,174	-835	132,339 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0 23.00
24.00	Dental	0	0	0	0	0 24.00
25.00	Optometry	0	0	0	0	0 25.00
25.01	Telehealth	0	0	0	835	835 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)	0	0	0	835	835 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	8,404	8,404	0	8,404 29.00
30.00	Administrative Costs	38,843	12,831	51,674	-19,172	32,502 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	38,843	21,235	60,078	-19,172	40,906 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	137,608	55,644	193,252	-19,172	174,080 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1337

Period:

Worksheet M-1

Component CCN: 14-8583

From 07/01/2021
To 09/30/2021Date/Time Prepared:
2/24/2022 11:43 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	22,193		1.00
2.00	Physician Assistant	0	3,120		2.00
3.00	Nurse Practitioner	0	51,808		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	11,791		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	33,566		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	122,478		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	9,861		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	9,861		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	132,339		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	835		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	835		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	8,404		29.00
30.00	Administrative Costs	0	32,502		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	40,906		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	174,080		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1337

Period:

Worksheet M-2

Component CCN: 14-8549

From 07/01/2021
To 09/30/2021Date/Time Prepared:
2/24/2022 11:43 am

				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	0.45	1,976	4,200	1,890		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.67	2,212	2,100	1,407		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.12	4,188		3,297	4,188	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	181			181	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)	1.12	4,369			4,369	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)					712,077	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					45,210	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					757,287	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.940300	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					116,962	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					374,080	15.00
16.00	Total overhead (sum of lines 14 and 15)					491,042	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					491,042	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					461,727	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,173,804	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1337

Period:

Worksheet M-2

Component CCN: 14-8583

From 07/01/2021
To 09/30/2021Date/Time Prepared:
2/24/2022 11:43 am

				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	0.06	198	4,200	252		1.00
2.00	Physician Assistant	0.07	244	2,100	147		2.00
3.00	Nurse Practitioner	0.30	1,314	2,100	630		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.43	1,756		1,029	1,756	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)	0.43	1,756			1,756	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)					132,339	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					835	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					133,174	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.993730	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					40,906	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					81,781	15.00
16.00	Total overhead (sum of lines 14 and 15)					122,687	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					122,687	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					121,918	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					254,257	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 07/01/2021 To 09/30/2021	Worksheet M-3	
		Component CCN: 14-8549		Date/Time Prepared: 2/24/2022 11:43 am	
		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)			1,173,804	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			12,020	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,161,784	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,369	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			4,369	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			265.92	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	1,633	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	416,366	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	416,366	16.00
16.01	Total program charges (see instructions)(from contractor's records)			299,810	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			33,877	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			47,047	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.)			290,767	16.04
16.05	Total program cost (see instructions)		0	337,814	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			5,860	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			51,965	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			337,814	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			6,152	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			343,966	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			343,966	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			335,805	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)			8,161	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 07/01/2021 To 09/30/2021	Worksheet M-3	
		Component CCN: 14-8583		Date/Time Prepared: 2/24/2022 11:43 am	
		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)			254,257	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			142	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			254,115	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,756	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			1,756	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			144.71	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	144.71	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	245	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	35,454	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	35,454	16.00
16.01	Total program charges (see instructions)(from contractor's records)			40,537	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	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.)			27,392	16.04
16.05	Total program cost (see instructions)		0	27,392	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			1,214	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			7,865	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			27,392	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			57	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			27,449	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			27,449	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			33,046	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)			-5,597	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 07/01/2021
To 09/30/2021Date/Time Prepared:
2/24/2022 11:43 am

		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)	666,577	666,577	666,577	666,577	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001367	0.001336	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	911	891	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	4,449	1,041	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	5,360	1,932	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	712,077	712,077	712,077	712,077	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	461,727	461,727	461,727	461,727	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.007527	0.002713	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,475	1,253	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	8,835	3,185	0	0	10.00
11.00	Total number of injections/infusions (from your records)	86	84	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	102.73	37.92	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	37	62	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)	3,801	2,351	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		12,020			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)		6,152			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1337

Period:

Worksheet M-4

Component CCN: 14-8583

From 07/01/2021
To 09/30/2021Date/Time Prepared:
2/24/2022 11:43 am

		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)	122,478	122,478	122,478	122,478	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000323	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	40	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	34	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	74	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	132,339	132,339	132,339	132,339	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	121,918	121,918	121,918	121,918	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.000559	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	68	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	142	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	5	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	28.40	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	2	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	57	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)		142			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)		57			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1337 Component CCN: 14-8549	Period: From 07/01/2021 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/24/2022 11:43 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		335,805	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)		335,805	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		8,161	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		343,966	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1337 Component CCN: 14-8583	Period: From 07/01/2021 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/24/2022 11:43 am	
		RHC II	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		33,046	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)		33,046	4.00	
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00	
Program to Provider					
5.01			0	5.01	
5.02			0	5.02	
5.03			0	5.03	
Provider to Program					
5.50			0	5.50	
5.51			0	5.51	
5.52			0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00	
6.01	SETTLEMENT TO PROVIDER		0	6.01	
6.02	SETTLEMENT TO PROGRAM		5,597	6.02	
7.00	Total Medicare program liability (see instructions)		27,449	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00 2.00		
8.00	Name of Contractor				8.00