

State Copy

Health Financial Systems PINCKNEYVILLE COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1307	Period: From 05/01/2020 To 04/30/2021	Worksheet S Parts I-III Date/Time Prepared: 9/28/2021 10:59 pm
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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.	Date: 9/28/2021	Time: 10:59 pm
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.	

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PINCKNEYVILLE COMMUNITY HOSPITAL (14-1307) for the cost reporting period beginning 05/01/2020 and ending 04/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) KARA JO CARSON
 Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
 Title
09/28/2021 10:59:53 PM
 Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	134,400	-982,960	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing Bed - SNF	0	171,183	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		213,544		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	305,583	-769,416	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.

Health Financial Systems		PINCKNEYVILLE COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10						
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1307		Period: From 05/01/2020 To 04/30/2021		Worksheet S-2 Part I Date/Time Prepared: 9/28/2021 10:59 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 5383 STATE ROUTE 154		PO Box:						1.00	
2.00	City: PINCKNEYVILLE		State: IL		Zip Code: 62274-1034		County: PERRY		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		PINCKNEYVILLE COMMUNITY HOSPITAL	141307	99914	1	11/30/2000	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		PINCKNEYVILLE CRITICAL ACC SWING BED	14Z307	99914		02/06/2001	N	O	N
8.00	Swing Beds - NF									6.00
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									10.00
13.00	Separately Certified ASC									11.00
14.00	Hospital-Based Hospice									12.00
15.00	Hospital-Based Health Clinic - RHC		PINCKNEYVILLE HOSPITAL RHC	143412	99914		03/27/1995	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									13.00
17.00	Hospital-Based (CMHC) I									14.00
17.10	Hospital-Based (CORF) I									15.00
18.00	Renal Dialysis									16.00
19.00	Other									17.00
						From:		To:		
						1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					05/01/2020		04/30/2021		20.00
21.00	Type of Control (see instructions)					11				21.00
						1.00		2.00		
						2.00		3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				N	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	N			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				2	N			23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part I
Date/Time Prepared:
9/28/2021 10:59 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part I
Date/Time Prepared:
9/28/2021 10:59 pm

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00
		Y/N	IME	Direct GME	
		1.00	2.00	3.00	4.00
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
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)				0.00
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)				0.00
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)				0.00
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).				0.00
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)				0.00
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)				0.00
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count
		1.00	2.00	3.00	4.00
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00
					1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00
Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)			N	63.00

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

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

Health Financial Systems		PINCKNEYVILLE COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1307		Period: From 05/01/2020 To 04/30/2021 Worksheet S-2 Part I Date/Time Prepared: 9/28/2021 10:59 pm	
		V		XIX	
		1.00		2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		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.	Y	Y	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	
		1.00		2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00	
		1.00		2.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	64,241		0	
		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	
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	

Health Financial Systems		PINCKNEYVILLE COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1307		Period: From 05/01/2020 To 04/30/2021		
				Worksheet S-2 Part I Date/Time Prepared: 9/28/2021 10:59 pm		
		1.00	2.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00	
133.00	Removed and reserved				133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00	
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00	
		1.00	2.00	3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name:	Contractor's Name:		Contractor's Number:		
142.00	Street:	PO Box:				
143.00	City:	State:		Zip Code:		
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?		Y		144.00	
		1.00		2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146.00	
				1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00	
		Part A	Part B	Title V	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	Y	Y	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10
				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
		0	1.00	2.00	3.00	4.00
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.		Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)				168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part I
Date/Time Prepared:
9/28/2021 10:59 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

Health Financial Systems		PINCKNEYVILLE COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10				
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1307		Period: From 05/01/2020 To 04/30/2021 Worksheet S-2 Part II Date/Time Prepared: 9/28/2021 10:59 pm				
				Y/N	Date			
				1.00	2.00			
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.								
COMPLETED BY ALL HOSPITALS								
Provider Organization and Operation								
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N		1.00		
				Y/N	Date	V/I		
				1.00	2.00	3.00		
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N		2.00		
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N		3.00		
				Y/N	Type	Date		
				1.00	2.00	3.00		
Financial Data and Reports								
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A	4.00		
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			Y		5.00		
				Y/N	Legal Oper.			
				1.00	2.00			
Approved Educational Activities								
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N		6.00		
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N		7.00		
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N		8.00		
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N		9.00		
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N		10.00		
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N		11.00		
				Y/N				
				1.00				
Bad Debts								
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y		12.00		
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N		13.00		
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N		14.00		
Bed Complement								
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N		15.00		
				Part A		Part B		
				Y/N	Date	Y/N	Date	
				1.00	2.00	3.00	4.00	
PS&R Data								
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N		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	07/21/2021	Y	07/21/2021	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		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N		19.00

Health Financial Systems		PINCKNEYVILLE COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1307		Period: From 05/01/2020 To 04/30/2021 Worksheet S-2 Part II Date/Time Prepared: 9/28/2021 10:59 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		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.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		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?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PAUL	TRACZEK		41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	715-858-6619	PTRACZEK@WIPFLI.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet S-2
Part II
Date/Time Prepared:
9/28/2021 10:59 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part I
Date/Time Prepared:
9/28/2021 10:59 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	17	6,205	20,448.00	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)		17	6,205	20,448.00	0	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)		17	6,205	20,448.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		17				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: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part I
Date/Time Prepared:
9/28/2021 10:59 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	504	168	852			1.00
2.00	HMO and other (see instructions)	30	0				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	1,219	0	1,346			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	735			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,723	168	2,933			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)	1,723	168	2,933	0.00	175.01	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC	5,673	3,021	15,334	0.00	37.33	26.00
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	212.34	27.00
28.00	Observation Bed Days		35	322			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: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet S-3
Part I
Date/Time Prepared:
9/28/2021 10:59 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	147	37	248	1.00
2.00 HMO and other (see instructions)			10	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	147	37	248	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0		0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC	0.00					26.00
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		PINCKNEYVILLE COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1307 Component CCN: 14-3412		Period: From 05/01/2020 To 04/30/2021 Worksheet S-8 Date/Time Prepared: 9/28/2021 10:59 pm	
		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street	5383 STATE ROUTE 154			
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	PINCKNEYVILLE IL 62274			
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0			
		Grant Award		Date	
		1.00		2.00	
	Source of Federal Funds				
4.00	Community Health Center (Section 330(d), PHS Act)				
5.00	Migrant Health Center (Section 329(d), PHS Act)				
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				
7.00	Appalachian Regional Commission				
8.00	Look-Alikes				
9.00	OTHER (SPECIFY)				
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		5.00	
11.00	Facility hours of operations (1)				
	CLINIC		08:30	19:00	08:30
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		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)				
		County		4.00	
2.00	City, State, ZIP Code, County	PERRY			
		Tuesday		Wednesday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		Thursday		to	
		6.00		10.00	
11.00	Facility hours of operations (1)				
	CLINIC	19:00	08:30	19:00	08:30
		19:00		11.00	

Health Financial Systems		PINCKNEYVILLE COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1307	Period: From 05/01/2020	Worksheet S-8
			Component CCN: 14-3412	To 04/30/2021	Date/Time Prepared: 9/28/2021 10:59 pm
			RHC I		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:30	17:00	09:00	12:00
					11.00

Health Financial Systems		PINCKNEYVILLE COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1307	Period: From 05/01/2020 To 04/30/2021	Worksheet S-10 Date/Time Prepared: 9/28/2021 10:59 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.549715	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			2,469,542	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			6,074,228	6.00
7.00	Medicaid cost (line 1 times line 6)			3,339,094	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)			869,552	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			283,862	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			869,552	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	745,025	637,218	1,382,243	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	409,551	637,218	1,046,769	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	409,551	637,218	1,046,769	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			508,106	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			176,848	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			272,074	27.01
28.00	Non-Medicare bad debt expense (see instructions)			236,032	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			224,976	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,271,745	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,141,297	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-1307	Period: From 05/01/2020 To 04/30/2021	Worksheet A Date/Time Prepared: 9/28/2021 10:59 pm
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,011,984	2,011,984	896,899	2,908,883
1.01	00101	NEW CAP REL COSTS-NEW BLDG	0	0	0	0
1.02	00102	NEW CAP REL COSTS-PT BLDG	0	0	17	17
1.03	00103	CAP REL COSTS-203 N WALNUT BLDG	0	0	1,236	1,236
1.04	00104	CAP REL COSTS-15 N MAIN BLDG	0	0	0	0
2.00	00200	CAP REL COSTS-MVBLE EQUIP	616,029	616,029	0	616,029
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	0	0
3.00	00300	OTHER CAP REL COSTS	0	0	0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	95,737	3,963,512	60,313	4,119,562
5.00	00500	ADMINISTRATIVE & GENERAL	1,747,590	1,526,181	-54,237	3,219,534
6.00	00600	MAINTENANCE & REPAIRS	318,953	658,122	-2,237	974,838
8.00	00800	LAUNDRY & LINEN SERVICE	0	119,647	0	119,647
9.00	00900	HOUSEKEEPING	409,189	57,928	0	467,117
10.00	01000	DIETARY	376,233	177,786	0	554,019
11.00	01100	CAFETERIA	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	727,469	90,949	0	818,418
14.00	01400	CENTRAL SERVICES & SUPPLY	33,629	2,868	0	36,497
15.00	01500	PHARMACY	432,568	2,594,360	-51,603	2,975,325
16.00	01600	MEDICAL RECORDS & LIBRARY	366,376	31,618	0	397,994
17.00	01700	SOCIAL SERVICE	43,672	4,715	0	48,387
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	289,200	0	289,200
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,769,169	182,031	132,017	2,083,217
41.00	04100	SUBPROVIDER - IRF	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	210,507	270,746	-83,959	397,294
53.00	05300	ANESTHESIOLOGY	0	8,690	0	8,690
54.00	05400	RADIOLOGY-DIAGNOSTIC	501,630	172,940	45	674,615
54.01	05401	ONCOLOGY	250,398	304,368	-986	553,780
56.00	05600	RADIOISOTOPE	79,147	53,932	0	133,079
57.00	05700	CT SCAN	54,749	98,800	0	153,549
58.00	05800	MRI	0	157,729	0	157,729
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0
60.00	06000	LABORATORY	610,586	731,193	3,413	1,345,192
60.01	06001	BLOOD LABORATORY	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	254,841	85,885	-1,531	339,195
66.00	06600	PHYSICAL THERAPY	541,910	26,147	71,686	639,743
67.00	06700	OCCUPATIONAL THERAPY	170,837	2,689	21,680	195,206
68.00	06800	SPEECH PATHOLOGY	93,903	5,725	3,532	103,160
69.00	06900	ELECTROCARDIOLOGY	2,230	20,755	0	22,985
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	183,716	183,716
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	33,145	33,145
73.00	07300	DRUGS CHARGED TO PATIENTS	16,727	784,607	0	801,334
76.00	03950	SENIOR LIFE SOLUTIONS	181,728	110,899	0	292,627
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0
76.02	03030	SLEEP STUDY	0	56,900	0	56,900
76.97	07697	CARDIAC REHABILITATION	41,758	3,802	0	45,560
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,849,612	371,658	-251,076	2,970,194
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0
90.00	09000	CLINIC	15,237	167,270	0	182,507
90.01	09002	COUMADIN, CHF/COPD CLINC	19,815	3,307	0	23,122
90.02	04050	TELEMEDICINE	0	0	0	0
91.00	09100	EMERGENCY	534,135	1,704,446	-13,650	2,224,931
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	845,049	-845,049	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,750,335	18,314,467	103,371	31,168,173
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,722	17,014	0	24,736
192.01	19201	FITNESS CENTER	161,208	8,870	-105,608	64,470
192.02	19202	RETAIL PHARMACY	0	0	0	0
192.03	19203	LEASED SPACE	0	0	0	0

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1307

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

Worksheet A

Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
192.04	19204	VACANT SPACE	0	908	908	2,237	3,145	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
200.00		TOTAL (SUM OF LINES 118 through 199)	12,919,265	18,341,259	31,260,524	0	31,260,524	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet A
Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-116,104	2,792,779	1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG	0	0	1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG	0	17	1.02
1.03	00103	CAP REL COSTS-203 N WALNUT BLDG	0	1,236	1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG	0	0	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-16,597	599,432	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	2.01
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-5,454	4,114,108	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-75,977	3,143,557	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	974,838	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	119,647	8.00
9.00	00900	HOUSEKEEPING	0	467,117	9.00
10.00	01000	DIETARY	-68,101	485,918	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	818,418	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-2,476	34,021	14.00
15.00	01500	PHARMACY	-6,956	2,968,369	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,060	393,934	16.00
17.00	01700	SOCIAL SERVICE	0	48,387	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	289,200	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-158,954	1,924,263	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-38,776	358,518	50.00
53.00	05300	ANESTHESIOLOGY	0	8,690	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-6,395	668,220	54.00
54.01	05401	ONCOLOGY	-282,000	271,780	54.01
56.00	05600	RADIOISOTOPE	0	133,079	56.00
57.00	05700	CT SCAN	0	153,549	57.00
58.00	05800	MRI	0	157,729	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-34,112	1,311,080	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	-4,018	335,177	65.00
66.00	06600	PHYSICAL THERAPY	-2,054	637,689	66.00
67.00	06700	OCCUPATIONAL THERAPY	-1,968	193,238	67.00
68.00	06800	SPEECH PATHOLOGY	-33,739	69,421	68.00
69.00	06900	ELECTROCARDIOLOGY	-11,994	10,991	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	183,716	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	33,145	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-801,334	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	292,627	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	76.01
76.02	03030	SLEEP STUDY	-2,900	54,000	76.02
76.97	07697	CARDIAC REHABILITATION	0	45,560	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-85,630	2,884,564	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-28,771	153,736	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	23,122	90.01
90.02	04050	TELEMEDICINE	0	0	90.02
91.00	09100	EMERGENCY	-338,861	1,886,070	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,127,231	29,040,942	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	24,736	192.00
192.01	19201	FITNESS CENTER	0	64,470	192.01
192.02	19202	RETAIL PHARMACY	0	0	192.02
192.03	19203	LEASED SPACE	0	0	192.03
192.04	19204	VACANT SPACE	0	3,145	192.04
192.05	19205	MEALS ON WHEELS	0	0	192.05

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1307

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

Worksheet A

Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description			Adjustments	Net Expenses	
			(See A-8)	For Allocation	
192.06	19206	15 N MAIN BUILDING	6.00	7.00	
200.00		TOTAL (SUM OF LINES 118 through 199)	0	0	192.06
			-2,127,231	29,133,293	200.00

	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	843,915		1.00
2.00	LABORATORY	60.00	0	28		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,106		3.00
	TOTALS		0	845,049		
	B - RECLASS WELLNESS CENTER					
1.00	PHYSICAL THERAPY	66.00	67,048	4,638		1.00
2.00	OCCUPATIONAL THERAPY	67.00	20,277	1,403		2.00
3.00	SPEECH PATHOLOGY	68.00	3,303	229		3.00
4.00	FITNESS CENTER	192.01	715	50		4.00
	TOTALS		91,343	6,320		
	C - RHC PHYSICIAN					
1.00	ADULTS & PEDIATRICS	30.00	138,066	7,545		1.00
	TOTALS		138,066	7,545		
	D - DEPRECIATION					
1.00	NEW CAP REL COSTS-PT BLDG	1.02	0	17		1.00
2.00	CAP REL COSTS-203 N WALNUT BLDG	1.03	0	1,236		2.00
	TOTALS		0	1,253		
	E - RHC LAB					
1.00	LABORATORY	60.00	1,527	1,858		1.00
	TOTALS		1,527	1,858		
	F - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	54,237		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	54,237		
	G - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	33,145		1.00
	TOTALS		0	33,145		
	H - MEDICAL SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	183,716		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	TOTALS		0	183,716		
	I - FITNESS CENTER RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8,710		1.00
	TOTALS		0	8,710		
	J - VACANT SPACE RECLASS					
1.00	VACANT SPACE	192.04	0	2,237		1.00
	TOTALS		0	2,237		
	K - RECLASS EMPLOYEE SCRIPTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	51,603	0		1.00
	TOTALS		51,603	0		
500.00	Grand Total: Increases		282,539	1,144,070		500.00

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	845,049	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
	TOTALS		0	845,049			
	B - RECLASS WELLNESS CENTER						
1.00	FITNESS CENTER	192.01	91,343	6,320	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		91,343	6,320			
	C - RHC PHYSICIAN						
1.00	RURAL HEALTH CLINIC	88.00	138,066	7,545	0		1.00
	TOTALS		138,066	7,545			
	D - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,253	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	1,253			
	E - RHC LAB						
1.00	RURAL HEALTH CLINIC	88.00	1,527	1,858	0		1.00
	TOTALS		1,527	1,858			
	F - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	54,237	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	54,237			
	G - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	33,145	0		1.00
	TOTALS		0	33,145			
	H - MEDICAL SUPPLIES RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	13,594	0		1.00
2.00	OPERATING ROOM	50.00	0	50,814	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,061	0		3.00
4.00	ONCOLOGY	54.01	0	986	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	1,531	0		5.00
6.00	RURAL HEALTH CLINIC	88.00	0	102,080	0		6.00
7.00	EMERGENCY	91.00	0	13,650	0		7.00
	TOTALS		0	183,716			
	I - FITNESS CENTER RECLASS						
1.00	FITNESS CENTER	192.01	0	8,710	0		1.00
	TOTALS		0	8,710			
	J - VACANT SPACE RECLASS						
1.00	MAINTENANCE & REPAIRS	6.00	0	2,237	0		1.00
	TOTALS		0	2,237			
	K - RECLASS EMPLOYEE SCRIPTS						
1.00	PHARMACY	15.00	51,603	0	0		1.00
	TOTALS		51,603	0			
500.00	Grand Total: Decreases		282,539	1,144,070			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet A-7
Part I
Date/Time Prepared:
9/28/2021 10:59 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	522,113	0	0	0	100,000	1.00
2.00	Land Improvements	3,201,568	226,391	0	226,391	47,518	2.00
3.00	Buildings and Fixtures	34,809,501	739,735	0	739,735	1,384,264	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	6,070,558	619,793	0	619,793	750,289	6.00
7.00	HIT designated Assets	1,682,322	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	46,286,062	1,585,919	0	1,585,919	2,282,071	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	46,286,062	1,585,919	0	1,585,919	2,282,071	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	422,113	0				1.00
2.00	Land Improvements	3,380,441	0				2.00
3.00	Buildings and Fixtures	34,164,972	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	5,940,062	0				6.00
7.00	HIT designated Assets	1,682,322	0				7.00
8.00	Subtotal (sum of lines 1-7)	45,589,910	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	45,589,910	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet A-7
Part II
Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,011,984	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-NEW BLDG	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-PT BLDG	0	0	0	0	0	1.02
1.03	CAP REL COSTS-203 N WALNUT BLDG	0	0	0	0	0	1.03
1.04	CAP REL COSTS-15 N MAIN BLDG	0	0	0	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	616,029	0	0	0	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,628,013	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		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	2,011,984				1.00
1.01	NEW CAP REL COSTS-NEW BLDG	0	0				1.01
1.02	NEW CAP REL COSTS-PT BLDG	0	0				1.02
1.03	CAP REL COSTS-203 N WALNUT BLDG	0	0				1.03
1.04	CAP REL COSTS-15 N MAIN BLDG	0	0				1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	616,029				2.00
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0				2.01
3.00	Total (sum of lines 1-2)	0	2,628,013				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet A-7
Part III
Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
		1.00	2.00	3.00	4.00	5.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	34,164,972	0	34,164,972	0.817591	0	1.00	
1.01	NEW CAP REL COSTS-NEW BLDG	0	0	0	0.000000	0	1.01	
1.02	NEW CAP REL COSTS-PT BLDG	0	0	0	0.000000	0	1.02	
1.03	CAP REL COSTS-203 N WALNUT BLDG	0	0	0	0.000000	0	1.03	
1.04	CAP REL COSTS-15 N MAIN BLDG	0	0	0	0.000000	0	1.04	
2.00	CAP REL COSTS-MVBLE EQUIP	7,622,384	0	7,622,384	0.182409	0	2.00	
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	0	0.000000	0	2.01	
3.00	Total (sum of lines 1-2)	41,787,356	0	41,787,356	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	2,010,731	0	1.00	
1.01	NEW CAP REL COSTS-NEW BLDG	0	0	0	0	0	1.01	
1.02	NEW CAP REL COSTS-PT BLDG	0	0	0	17	0	1.02	
1.03	CAP REL COSTS-203 N WALNUT BLDG	0	0	0	1,236	0	1.03	
1.04	CAP REL COSTS-15 N MAIN BLDG	0	0	0	0	0	1.04	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	599,432	0	2.00	
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	0	0	0	2.01	
3.00	Total (sum of lines 1-2)	0	0	0	2,611,416	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	727,811	54,237	0	0	2,792,779	1.00	
1.01	NEW CAP REL COSTS-NEW BLDG	0	0	0	0	0	1.01	
1.02	NEW CAP REL COSTS-PT BLDG	0	0	0	0	17	1.02	
1.03	CAP REL COSTS-203 N WALNUT BLDG	0	0	0	0	1,236	1.03	
1.04	CAP REL COSTS-15 N MAIN BLDG	0	0	0	0	0	1.04	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	599,432	2.00	
2.01	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0	0	0	0	2.01	
3.00	Total (sum of lines 1-2)	727,811	54,237	0	0	3,393,464	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1307

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

Worksheet A-8

Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.	
				Cost Center				
1.00		B	-116,104	CAP REL COSTS-BLDG & FIXT		1.00	11	1.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)							
1.01	Investment income - NEW CAP REL COSTS-NEW BLDG (chapter 2)			0 NEW CAP REL COSTS-NEW BLDG		1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-PT BLDG (chapter 2)			0 NEW CAP REL COSTS-PT BLDG		1.02	0	1.02
1.03	Investment income - CAP REL COSTS-203 N WALNUT BLDG (chapter 2)			0 CAP REL COSTS-203 N WALNUT BLDG		1.03	0	1.03
1.04	Investment income - CAP REL COSTS-15 N MAIN BLDG (chapter 2)			0 CAP REL COSTS-15 N MAIN BLDG		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
2.01	Investment income - CAP REL COSTS-MVBLE EQUIP NEW BLDG (chapter 2)			0 CAP REL COSTS-MVBLE EQUIP NEW BLDG		2.01	0	2.01
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)	B	-1,176	PHARMACY		15.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0			0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0			0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-4,825	ADMINISTRATIVE & GENERAL		5.00	0	8.00
9.00	Parking lot (chapter 21)		0			0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-856,132				0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0			0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0				0	12.00
13.00	Laundry and linen service		0			0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-65,674	DIETARY		10.00	0	14.00
15.00	Rental of quarters to employee and others		0			0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0			0.00	0	16.00
17.00	Sale of drugs to other than patients		0			0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,060	MEDICAL RECORDS & LIBRARY		16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0			0.00	0	19.00
20.00	Vending machines	B	0	ADMINISTRATIVE & GENERAL		5.00	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 - NEW CAP REL COSTS-NEW BLDG		0	NEW CAP REL COSTS-NEW BLDG		1.01	0	26.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1307

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

Worksheet A-8

Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
26.02	Depreciation - NEW CAP REL COSTS-PT BLDG			0 NEW CAP REL COSTS-PT BLDG	1.02	0	26.02
26.03	Depreciation - CAP REL COSTS-203 N WALNUT BLDG			0 CAP REL COSTS-203 N WALNUT BLDG	1.03	0	26.03
26.04	Depreciation - CAP REL COSTS-15 N MAIN BLDG			0 CAP REL COSTS-15 N MAIN BLDG	1.04	0	26.04
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0 CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - CAP REL COSTS-MVBLE EQUIP NEW BLDG			0 CAP REL COSTS-MVBLE EQUIP NEW BLDG	2.01	0	27.01
28.00	Non-physician Anesthetist			0 NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0 OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0 ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0 SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-16,597	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	NONPATIENT CARE RELATED PROPERTY INS	A	-1,221	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	MISCELLANEOUS INCOME	B	-1,936	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	AMBULANCE RX	A	-5,780	PHARMACY	15.00	0	34.01
34.02	REBATE - CENTRAL SUPPLY	B	-2,476	CENTRAL SERVICES & SUPPLY	14.00	0	34.02
34.03	REBATE - DIETARY	B	-2,079	DIETARY	10.00	0	34.03
35.00	NON-ALLOWABLE LOBBYING	A		-8 ADULTS & PEDIATRICS	30.00	0	35.00
36.00	MOBILE PET SCAN RENTAL	B	-4,950	RADIOLOGY-DIAGNOSTIC	54.00	0	36.00
37.00	NON-ALLOWABLE LOBBYING	A	-9,900	ADMINISTRATIVE & GENERAL	5.00	0	37.00
37.01	NON-ALLOWABLE LOBBYING	A	-1	DIETARY	10.00	0	37.01
37.02	NON-ALLOWABLE LOBBYING	A	-5	RADIOLOGY-DIAGNOSTIC	54.00	0	37.02
37.05	NON-ALLOWABLE LOBBYING	A	-1,156	RURAL HEALTH CLINIC	88.00	0	37.05
37.06	NON-ALLOWABLE LOBBYING	A	-12	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.06
37.07	NON-ALLOWABLE LOBBYING	A	-18	RESPIRATORY THERAPY	65.00	0	37.07
38.00	NON-ALLOWABLE LOBBYING	A	-105	PHYSICAL THERAPY	66.00	0	38.00
39.00	NON-ALLOWABLE ADVERTISING	A	-35,727	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	GIFTS & DONATIONS	A	-1,151	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	UNALLOWABLE TRANSPORT ASSET	A	-869	EMERGENCY	91.00	0	41.00
42.00	COMMUNITY EDUCATION	A	-11,863	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	OUTSIDE SERVICES - PHYSICAL THERAPY	B	-1,949	PHYSICAL THERAPY	66.00	0	43.00
43.01	OUTSIDE SERVICES - OCCUP THERAPY	B	-1,968	OCCUPATIONAL THERAPY	67.00	0	43.01
43.02	OUTSIDE SERVICES - SPEECH PATHOLOGY	B	-33,739	SPEECH PATHOLOGY	68.00	0	43.02
43.04	OUTSIDE SERVICES - LAB	B	-28,957	LABORATORY	60.00	0	43.04
44.00	LIABILITY CLAIMS	A	-2,290	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	SPECIALTY CLINIC SUPPORT	A	-9,247	CLINIC	90.00	0	45.00
46.00	DIETICIAN'S CONSULTS	B	-347	DIETARY	10.00	0	46.00
47.00	OTHER ADJUSTMENTS (SPECIFY) (3)			0	0.00	0	47.00
48.00	340B EXPENSES	A	-801,334	DRUGS CHARGED TO PATIENTS	73.00	0	48.00
48.01	COMMUNICATIONS REBATE	B	-414	ADMINISTRATIVE & GENERAL	5.00	0	48.01
48.02	RENT	B	-6,650	ADMINISTRATIVE & GENERAL	5.00	0	48.02
48.03	REBATE - IMAGING	B	-1,440	RADIOLOGY-DIAGNOSTIC	54.00	0	48.03
48.04	REBATE - LAB	B	-5,155	LABORATORY	60.00	0	48.04
48.05	LEASED PHYSICIAN	B	-84,474	RURAL HEALTH CLINIC	88.00	0	48.05
48.06	PHYSICIAN RECRUITMENT	A	-5,442	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	48.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,127,231				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1307

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

Worksheet A-8-2

Date/Time Prepared:
9/28/2021 10:59 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. F	41,862	41,862	0	0	0	1.00
2.00	30.00	DR. R	45,148	45,148	0	0	0	2.00
3.00	30.00	DR. F	29,647	29,647	0	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	1,609,484	337,992	1,271,492	0	0	4.00
5.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	13,334	13,334	0	0	0	5.00
6.00	54.01	AGGREGATE-ONCOLOGY	282,000	282,000	0	0	0	6.00
7.00	60.00	AGGREGATE-LABORATORY	29,850	0	29,850	0	0	7.00
8.00	65.00	AGGREGATE-RESPIRATORY THERAPY	4,000	4,000	0	0	0	8.00
9.00	76.02	AGGREGATE-SLEEP STUDY	2,900	2,900	0	0	0	9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	11,994	11,994	0	0	0	10.00
11.00	76.00	AGGREGATE-SENIOR LIFE SOLUTIONS	30,000	0	30,000	0	0	11.00
12.00	50.00	AGGREGATE-OPERATING ROOM	38,776	38,776	0	0	0	12.00
13.00	90.00	AGGREGATE-CLINIC	19,524	19,524	0	0	0	13.00
14.00	30.00	DR. H	28,955	28,955	0	0	0	14.00
200.00			2,187,474	856,132	1,331,342			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	DR. F	0	0	0	0	0	1.00
2.00	30.00	DR. R	0	0	0	0	0	2.00
3.00	30.00	DR. F	0	0	0	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	4.00
5.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	54.01	AGGREGATE-ONCOLOGY	0	0	0	0	0	6.00
7.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	7.00
8.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	8.00
9.00	76.02	AGGREGATE-SLEEP STUDY	0	0	0	0	0	9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0	0	10.00
11.00	76.00	AGGREGATE-SENIOR LIFE SOLUTIONS	0	0	0	0	0	11.00
12.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	12.00
13.00	90.00	AGGREGATE-CLINIC	0	0	0	0	0	13.00
14.00	30.00	DR. H	0	0	0	0	0	14.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	DR. F	0	0	0	41,862		1.00
2.00	30.00	DR. R	0	0	0	45,148		2.00
3.00	30.00	DR. F	0	0	0	29,647		3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	337,992		4.00
5.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	13,334		5.00
6.00	54.01	AGGREGATE-ONCOLOGY	0	0	0	282,000		6.00
7.00	60.00	AGGREGATE-LABORATORY	0	0	0	0		7.00
8.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	4,000		8.00
9.00	76.02	AGGREGATE-SLEEP STUDY	0	0	0	2,900		9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	11,994		10.00
11.00	76.00	AGGREGATE-SENIOR LIFE SOLUTIONS	0	0	0	0		11.00
12.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	38,776		12.00
13.00	90.00	AGGREGATE-CLINIC	0	0	0	19,524		13.00
14.00	30.00	DR. H	0	0	0	28,955		14.00
200.00			0	0	0	856,132		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1307		Period: From 05/01/2020 To 04/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/28/2021 10:59 pm	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					4	1.00
2.00	Line 1 multiplied by 15 hours per week					60	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					13	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.70	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	111.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	83.88	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.94	41.94	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					9,311	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					9,311	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					9,311	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					9,311	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					545	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					545	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					74	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					619	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					619	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					74	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1307		Period: From 05/01/2020 To 04/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/28/2021 10:59 pm		
		Physical Therapy				Cost		
						1.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	83.88	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						9,311	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						619	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						9,930	63.00
64.00	Total cost of outside supplier services (from your records)						8,991	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						545	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						74	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						619	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						74	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						74	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

Health Financial Systems		PINCKNEYVILLE COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10		
REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1307		Period: From 05/01/2020 To 04/30/2021		
				Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/28/2021 10:59 pm		
		Occupational Therapy		Cost		
				1.00		
PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)			3	1.00	
2.00	Line 1 multiplied by 15 hours per week			45	2.00	
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)			5	3.00	
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)			0	4.00	
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)			0	5.00	
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)			0	6.00	
7.00	Standard travel expense rate			5.70	7.00	
8.00	Optional travel expense rate per mile			0.00	8.00	
		Supervisors	Therapists	Assistants	Aides	Trainees
		1.00	2.00	3.00	4.00	5.00
9.00	Total hours worked	0.00	14.00	0.00	0.00	0.00
10.00	AHSEA (see instructions)	0.00	79.51	0.00	0.00	0.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.76	39.76	0.00		
12.00	Number of travel hours (provider site)	0	0	0		
12.01	Number of travel hours (offsite)	0	0	0		
13.00	Number of miles driven (provider site)	0	0	0		
13.01	Number of miles driven (offsite)	0	0	0		
				1.00		
Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)			0	14.00	
15.00	Therapists (column 2, line 9 times column 2, line 10)			1,113	15.00	
16.00	Assistants (column 3, line 9 times column 3, line 10)			0	16.00	
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)			1,113	17.00	
18.00	Aides (column 4, line 9 times column 4, line 10)			0	18.00	
19.00	Trainees (column 5, line 9 times column 5, line 10)			0	19.00	
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)			1,113	20.00	
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)			79.50	21.00	
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)			3,578	22.00	
23.00	Total salary equivalency (see instructions)			3,578	23.00	
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)			199	24.00	
25.00	Assistants (line 4 times column 3, line 11)			0	25.00	
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)			199	26.00	
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)			29	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)			228	28.00	
Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)			0	29.00	
30.00	Assistants (column 3, line 10 times column 3, line 12)			0	30.00	
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)			0	31.00	
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)			0	32.00	
33.00	Standard travel allowance and standard travel expense (line 28)			228	33.00	
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)			29	34.00	
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)			0	35.00	
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)			0	36.00	
37.00	Assistants (line 6 times column 3, line 11)			0	37.00	
38.00	Subtotal (sum of lines 36 and 37)			0	38.00	
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)			0	39.00	
Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)			0	40.00	
41.00	Assistants (column 3, line 12.01 times column 3, line 10)			0	41.00	
42.00	Subtotal (sum of lines 40 and 41)			0	42.00	
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)			0	43.00	
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1307		Period: From 05/01/2020 To 04/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/28/2021 10:59 pm	
				Occupational Therapy		Cost	
						1.00	
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	79.51	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					3,578	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					228	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					3,806	63.00
64.00	Total cost of outside supplier services (from your records)					840	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					199	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					29	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					228	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					29	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					29	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW NEW BLDG	NEW PT BLDG	203 N WALNUT BLDG	
			0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,792,779	2,792,779				1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG	0	0	0			1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG	17	0	0	17		1.02
1.03	00103	CAP REL COSTS-203 N WALNUT BLDG	1,236	0	0	0	1,236	1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG	0		0	0		1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	599,432					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,114,108	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,143,557	569,757	0	0	204	5.00
6.00	00600	MAINTENANCE & REPAIRS	974,838	154,481	0	0	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	119,647	10,990	0	0	0	8.00
9.00	00900	HOUSEKEEPING	467,117	21,980	0	0	0	9.00
10.00	01000	DIETARY	485,918	103,400	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	818,418	10,784	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	34,021	35,344	0	0	0	14.00
15.00	01500	PHARMACY	2,968,369	34,828	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	393,934	35,060	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	48,387	2,451	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	289,200	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,924,263	244,053	0	0	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	358,518	239,280	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	8,690	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	668,220	143,052	0	0	0	54.00
54.01	05401	ONCOLOGY	271,780	71,204	0	0	0	54.01
56.00	05600	RADIOISOTOPE	133,079	7,636	0	0	0	56.00
57.00	05700	CT SCAN	153,549	23,502	0	0	0	57.00
58.00	05800	MRI	157,729	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,311,080	69,862	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	335,177	56,731	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	637,689	156,235	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	193,238	39,291	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	69,421	6,372	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,991	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	183,716	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,145	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	292,627	72,235	0	0	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	54,000	19,349	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	45,560	21,800	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,884,564	273,644	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	153,736	8,694	0	0	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	23,122	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	1,886,070	151,772	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,040,942	2,583,787	0	0	204	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,932	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	24,736	51,906	0	0	0	192.00
192.01	19201	FITNESS CENTER	64,470	134,255	0	0	0	192.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW NEW BLDG	NEW PT BLDG	203 N WALNUT BLDG	
			0	1.00	1.01	1.02	1.03	
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	12,899	0	0	0	192.03
192.04	19204	VACANT SPACE	3,145	0	0	17	1,032	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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)	29,133,293	2,792,779	0	17	1,236	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			15 N MAIN BLDG	MVBLE EQUIP	MVBLE EQUIP NEW BLDG			
			1.04	2.00	2.01	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	CAP REL COSTS-203 N WALNUT BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG	0					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		599,432				2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG		0	0			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	4,114,108		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	133,446	0	570,597	4,417,561	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	35,742	0	104,140	1,269,201	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,543	0	0	133,180	8.00
9.00	00900	HOUSEKEEPING	0	5,086	0	133,602	627,785	9.00
10.00	01000	DIETARY	0	23,924	0	122,842	736,084	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,495	0	237,522	1,069,219	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,177	0	10,980	88,522	14.00
15.00	01500	PHARMACY	0	8,058	0	124,387	3,135,642	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,112	0	119,624	556,730	16.00
17.00	01700	SOCIAL SERVICE	0	567	0	14,259	65,664	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	289,200	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	56,466	0	577,643	2,802,425	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	55,362	0	68,732	721,892	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	8,690	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	33,098	0	163,785	1,008,155	54.00
54.01	05401	ONCOLOGY	0	16,474	0	81,756	441,214	54.01
56.00	05600	RADIOISOTOPE	0	1,767	0	25,842	168,324	56.00
57.00	05700	CT SCAN	0	5,438	0	17,876	200,365	57.00
58.00	05800	MRI	0	0	0	0	157,729	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	16,164	0	199,858	1,596,964	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	13,126	0	83,207	488,241	65.00
66.00	06600	PHYSICAL THERAPY	0	36,148	0	198,828	1,028,900	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,091	0	62,400	304,020	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,474	0	31,738	109,005	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	728	11,719	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	183,716	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	33,145	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,461	5,461	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	16,713	0	59,335	440,910	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	0	4,477	0	0	77,826	76.02
76.97	07697	CARDIAC REHABILITATION	0	5,044	0	13,634	86,038	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	63,313	0	884,837	4,106,358	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	2,012	0	1,956	166,398	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	0	6,470	29,592	90.01
90.02	04050	TELEMEDICINE	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	35,115	0	174,398	2,247,355	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	599,432	0	4,096,437	28,813,230	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	9,932	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	2,521	79,163	192.00
192.01	19201	FITNESS CENTER	0	0	0	15,150	213,875	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	12,899	192.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			15 N MAIN BLDG	MVBLE EQUIP	MVBLE EQUIP NEW BLDG			
			1.04	2.00	2.01			
192.04	19204	VACANT SPACE	0	0	0	0	4,194	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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)	0	599,432	0	4,114,108	29,133,293	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	CAP REL COSTS-203 N WALNUT BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,417,561					5.00
6.00	00600	MAINTENANCE & REPAIRS	226,889	1,496,090				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,808	7,949	164,937			8.00
9.00	00900	HOUSEKEEPING	112,226	15,897	0	755,908		9.00
10.00	01000	DIETARY	131,586	74,785	0	62,571	1,005,026	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	191,139	7,799	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,825	25,563	0	2,266	0	14.00
15.00	01500	PHARMACY	560,543	25,190	0	10,283	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	99,524	25,357	0	5,403	0	16.00
17.00	01700	SOCIAL SERVICE	11,738	1,773	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	51,699	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	500,976	176,513	164,937	157,388	1,005,026	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	129,049	173,061	0	54,205	0	50.00
53.00	05300	ANESTHESIOLOGY	1,553	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	180,223	103,464	0	33,290	0	54.00
54.01	05401	ONCOLOGY	78,874	51,499	0	35,381	0	54.01
56.00	05600	RADIOISOTOPE	30,090	5,523	0	1,743	0	56.00
57.00	05700	CT SCAN	35,818	16,998	0	5,403	0	57.00
58.00	05800	MRI	28,196	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	285,481	50,528	0	41,482	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	87,280	41,031	0	1,917	0	65.00
66.00	06600	PHYSICAL THERAPY	183,931	112,998	0	41,307	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	54,348	28,418	0	8,017	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,486	4,609	0	1,917	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,095	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	32,842	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,925	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	976	0	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	78,819	52,245	0	23,704	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	13,913	13,994	0	4,532	0	76.02
76.97	07697	CARDIAC REHABILITATION	15,381	15,767	0	5,054	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	734,078	197,915	0	101,090	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	29,746	6,288	0	35,556	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	5,290	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	401,748	109,770	0	94,292	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,361,095	1,344,934	164,937	726,801	1,005,026	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	1,775	7,184	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,152	37,542	0	0	0	192.00
192.01	19201	FITNESS CENTER	38,233	97,101	0	26,144	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	2,306	9,329	0	2,963	0	192.03
192.04	19204	VACANT SPACE	0	0	0	0	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	4,417,561	1,496,090	164,937	755,908	1,005,026	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet B
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	CAP REL COSTS-203 N WALNUT BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	1,268,157				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	132,176			14.00
15.00	01500	PHARMACY	0	0	158	3,731,816		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	221	0	687,235	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	797,823	12,209	0	27,509	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	92,882	7,273	0	13,127	50.00
53.00	05300	ANESTHESIOLOGY	0	0	607	0	11,666	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	5,805	0	45,834	54.00
54.01	05401	ONCOLOGY	0	123,775	2,111	0	9,493	54.01
56.00	05600	RADIOISOTOPE	0	0	21	0	9,617	56.00
57.00	05700	CT SCAN	0	0	2,415	0	90,708	57.00
58.00	05800	MRI	0	0	28	0	17,652	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	48,828	0	131,020	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	2,416	0	7,926	65.00
66.00	06600	PHYSICAL THERAPY	0	0	670	0	50,094	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	115	0	15,108	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,974	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	48	0	4,884	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	28,016	0	7,964	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,061	0	1,584	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,731,816	136,628	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	0	249	0	5,391	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	7,928	76.01
76.02	03030	SLEEP STUDY	0	0	0	0	4,855	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	61	0	2,280	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	6,523	0	38,777	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	6,112	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	405	0	2,323	90.01
90.02	04050	TELEMEDICINE	0	0	0	0	60	90.02
91.00	09100	EMERGENCY	0	253,677	9,231	0	36,721	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,268,157	131,471	3,731,816	687,235	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	147	0	0	192.00
192.01	19201	FITNESS CENTER	0	0	558	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	VACANT SPACE	0	0	0	0	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
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9/28/2021 10:59 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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	1,268,157	132,176	3,731,816	687,235	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	CAP REL COSTS-203 N WALNUT BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	79,175					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	340,899				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	79,175	0	5,723,981	-39,807	5,684,174	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	1,191,489	0	1,191,489	50.00
53.00	05300	ANESTHESIOLOGY	0	340,899	363,415	0	363,415	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,376,771	0	1,376,771	54.00
54.01	05401	ONCOLOGY	0	0	742,347	0	742,347	54.01
56.00	05600	RADIOISOTOPE	0	0	215,318	0	215,318	56.00
57.00	05700	CT SCAN	0	0	351,707	0	351,707	57.00
58.00	05800	MRI	0	0	203,605	0	203,605	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	2,154,303	0	2,154,303	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	628,811	0	628,811	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,417,900	0	1,417,900	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	410,026	0	410,026	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	136,991	0	136,991	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	18,746	0	18,746	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	252,538	0	252,538	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	44,715	0	44,715	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,874,881	0	3,874,881	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	0	601,318	0	601,318	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	7,928	39,807	47,735	76.01
76.02	03030	SLEEP STUDY	0	0	115,120	0	115,120	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	124,581	0	124,581	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	5,184,741	0	5,184,741	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	244,100	0	244,100	90.00
90.01	09002	COUMADIN, CHF/COPD CLINC	0	0	37,610	0	37,610	90.01
90.02	04050	TELEMEDICINE	0	0	60	0	60	90.02
91.00	09100	EMERGENCY	0	0	3,152,794	0	3,152,794	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	79,175	340,899	28,575,796	0	28,575,796	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	18,891	0	18,891	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	131,004	0	131,004	192.00
192.01	19201	FITNESS CENTER	0	0	375,911	0	375,911	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	27,497	0	27,497	192.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part I
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Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
192.04	19204	VACANT SPACE	0	0	4,194	0	4,194	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	79,175	340,899	29,133,293	0	29,133,293	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW NEW BLDG	NEW PT BLDG	203 N WALNUT BLDG	
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	NEW CAP REL COSTS-NEW BLDG					1.01	
1.02	00102	NEW CAP REL COSTS-PT BLDG					1.02	
1.03	00103	CAP REL COSTS-203 N WALNUT BLDG					1.03	
1.04	00104	CAP REL COSTS-15 N MAIN BLDG					1.04	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG					2.01	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	0	569,757	0	0	5.00	
6.00	00600	MAINTENANCE & REPAIRS	0	154,481	0	0	6.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,990	0	0	8.00	
9.00	00900	HOUSEKEEPING	0	21,980	0	0	9.00	
10.00	01000	DIETARY	0	103,400	0	0	10.00	
11.00	01100	CAFETERIA	0	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	0	10,784	0	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	35,344	0	0	14.00	
15.00	01500	PHARMACY	0	34,828	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,060	0	0	16.00	
17.00	01700	SOCIAL SERVICE	0	2,451	0	0	17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	244,053	0	0	30.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	42.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	239,280	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	143,052	0	0	54.00	
54.01	05401	ONCOLOGY	0	71,204	0	0	54.01	
56.00	05600	RADIOISOTOPE	0	7,636	0	0	56.00	
57.00	05700	CT SCAN	0	23,502	0	0	57.00	
58.00	05800	MRI	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	69,862	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01	
65.00	06500	RESPIRATORY THERAPY	0	56,731	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	156,235	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	39,291	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	6,372	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	03950	SENIOR LIFE SOLUTIONS	0	72,235	0	0	76.00	
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	76.01	
76.02	03030	SLEEP STUDY	0	19,349	0	0	76.02	
76.97	07697	CARDIAC REHABILITATION	0	21,800	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	273,644	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00	
90.00	09000	CLINIC	0	8,694	0	0	90.00	
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	0	0	90.01	
90.02	04050	TELEMEDICINE	0	0	0	0	90.02	
91.00	09100	EMERGENCY	0	151,772	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00	
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	99.10	
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00	
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00	
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00	
113.00	11300	INTEREST EXPENSE					113.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,583,787	0	204	118.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,932	0	0	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	51,906	0	0	192.00	
192.01	19201	FITNESS CENTER	0	134,255	0	0	192.01	
192.02	19202	RETAIL PHARMACY	0	0	0	0	192.02	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

Period:
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To 04/30/2021Worksheet B
Part II
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW NEW BLDG	NEW PT BLDG	203 N WALNUT BLDG	
				1.00	1.01	1.02	1.03	
192.03	19203	LEASED SPACE	0	12,899	0	0	0	192.03
192.04	19204	VACANT SPACE	0	0	0	17	1,032	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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	2,792,779	0	17	1,236	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

Period:
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To 04/30/2021Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			15 N MAIN BLDG	MVBLE EQUIP	MVBLE EQUIP NEW BLDG			
			1.04	2.00	2.01	2A	4.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	CAP REL COSTS-203 N WALNUT BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	133,446	0	703,407	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	35,742	0	190,223	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,543	0	13,533	0	8.00
9.00	00900	HOUSEKEEPING	0	5,086	0	27,066	0	9.00
10.00	01000	DIETARY	0	23,924	0	127,324	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,495	0	13,279	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,177	0	43,521	0	14.00
15.00	01500	PHARMACY	0	8,058	0	42,886	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,112	0	43,172	0	16.00
17.00	01700	SOCIAL SERVICE	0	567	0	3,018	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	56,466	0	300,519	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	55,362	0	294,642	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	33,098	0	176,150	0	54.00
54.01	05401	ONCOLOGY	0	16,474	0	87,678	0	54.01
56.00	05600	RADIOISOTOPE	0	1,767	0	9,403	0	56.00
57.00	05700	CT SCAN	0	5,438	0	28,940	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	16,164	0	86,026	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	13,126	0	69,857	0	65.00
66.00	06600	PHYSICAL THERAPY	0	36,148	0	192,383	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,091	0	48,382	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,474	0	7,846	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	03950	SENIOR LIFE SOLUTIONS	0	16,713	0	88,948	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	0	4,477	0	23,826	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	5,044	0	26,844	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	63,313	0	336,957	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	2,012	0	10,706	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINC	0	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	35,115	0	186,887	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	599,432	0	3,183,423	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	9,932	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	51,906	0	192.00
192.01	19201	FITNESS CENTER	0	0	0	134,255	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	12,899	0	192.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

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

 Worksheet B
 Part II
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Cost Center Description			CAPITAL RELATED COSTS			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			15 N MAIN BLDG	MVBLE EQUIP	MVBLE EQUIP NEW BLDG			
			1.04	2.00	2.01			
192.04	19204	VACANT SPACE	0	0	0	1,049	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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)	0	599,432	0	3,393,464	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	CAP REL COSTS-203 N WALNUT BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	703,407					5.00
6.00	00600	MAINTENANCE & REPAIRS	36,128	226,351				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,791	1,203	18,527			8.00
9.00	00900	HOUSEKEEPING	17,870	2,405	0	47,341		9.00
10.00	01000	DIETARY	20,953	11,315	0	3,919	163,511	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	30,435	1,180	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,520	3,868	0	142	0	14.00
15.00	01500	PHARMACY	89,256	3,811	0	644	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,847	3,836	0	338	0	16.00
17.00	01700	SOCIAL SERVICE	1,869	268	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	8,232	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	79,771	26,706	18,527	9,856	163,511	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,549	26,183	0	3,395	0	50.00
53.00	05300	ANESTHESIOLOGY	247	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,697	15,654	0	2,085	0	54.00
54.01	05401	ONCOLOGY	12,559	7,791	0	2,216	0	54.01
56.00	05600	RADIOISOTOPE	4,791	836	0	109	0	56.00
57.00	05700	CT SCAN	5,703	2,572	0	338	0	57.00
58.00	05800	MRI	4,490	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	45,458	7,645	0	2,598	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	13,898	6,208	0	120	0	65.00
66.00	06600	PHYSICAL THERAPY	29,288	17,096	0	2,587	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,654	4,299	0	502	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,103	697	0	120	0	68.00
69.00	06900	ELECTROCARDIOLOGY	334	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	5,229	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	943	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	155	0	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	12,551	7,904	0	1,485	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	2,215	2,117	0	284	0	76.02
76.97	07697	CARDIAC REHABILITATION	2,449	2,385	0	317	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	116,881	29,943	0	6,331	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	4,737	951	0	2,227	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	842	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	63,971	16,608	0	5,905	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	694,416	203,481	18,527	45,518	163,511	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	283	1,087	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,253	5,680	0	0	0	192.00
192.01	19201	FITNESS CENTER	6,088	14,691	0	1,637	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	367	1,412	0	186	0	192.03
192.04	19204	VACANT SPACE	0	0	0	0	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

Period:
From 05/01/2020
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	703,407	226,351	18,527	47,341	163,511	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet B
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	CAP REL COSTS-203 N WALNUT BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	44,894				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	50,051			14.00
15.00	01500	PHARMACY	0	0	60	136,657		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	84	0	63,277	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	28,244	4,623	0	2,532	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,288	2,754	0	1,208	50.00
53.00	05300	ANESTHESIOLOGY	0	0	230	0	1,074	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,198	0	4,219	54.00
54.01	05401	ONCOLOGY	0	4,382	800	0	874	54.01
56.00	05600	RADIOISOTOPE	0	0	8	0	885	56.00
57.00	05700	CT SCAN	0	0	914	0	8,350	57.00
58.00	05800	MRI	0	0	11	0	1,625	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	18,490	0	12,061	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	915	0	730	65.00
66.00	06600	PHYSICAL THERAPY	0	0	254	0	4,612	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	43	0	1,391	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	182	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	18	0	450	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	10,609	0	733	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,538	0	146	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	136,657	12,590	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	0	94	0	496	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	730	76.01
76.02	03030	SLEEP STUDY	0	0	0	0	447	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	23	0	210	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	2,470	0	3,570	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	563	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	153	0	214	90.01
90.02	04050	TELEMEDICINE	0	0	0	0	5	90.02
91.00	09100	EMERGENCY	0	8,980	3,495	0	3,380	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	44,894	49,784	136,657	63,277	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	56	0	0	192.00
192.01	19201	FITNESS CENTER	0	0	211	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	VACANT SPACE	0	0	0	0	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

Period:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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	44,894	50,051	136,657	63,277	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet B
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Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	CAP REL COSTS-203 N WALNUT BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	5,155					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	8,232				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,155		639,444	0	639,444	30.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		352,019	0	352,019	50.00
53.00	05300	ANESTHESIOLOGY	0		1,551	0	1,551	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		229,003	0	229,003	54.00
54.01	05401	ONCOLOGY	0		116,300	0	116,300	54.01
56.00	05600	RADIOISOTOPE	0		16,032	0	16,032	56.00
57.00	05700	CT SCAN	0		46,817	0	46,817	57.00
58.00	05800	MRI	0		6,126	0	6,126	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	0		172,278	0	172,278	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0		91,728	0	91,728	65.00
66.00	06600	PHYSICAL THERAPY	0		246,220	0	246,220	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		63,271	0	63,271	67.00
68.00	06800	SPEECH PATHOLOGY	0		11,948	0	11,948	68.00
69.00	06900	ELECTROCARDIOLOGY	0		802	0	802	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		16,571	0	16,571	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		2,627	0	2,627	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		149,402	0	149,402	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0		111,478	0	111,478	76.00
76.01	03020	OP IV THERAPY/NURSING	0		730	0	730	76.01
76.02	03030	SLEEP STUDY	0		28,889	0	28,889	76.02
76.97	07697	CARDIAC REHABILITATION	0		32,228	0	32,228	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		496,152	0	496,152	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		19,184	0	19,184	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0		1,209	0	1,209	90.01
90.02	04050	TELEMEDICINE	0		5	0	5	90.02
91.00	09100	EMERGENCY	0		289,226	0	289,226	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0		0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,155	0	3,141,240	0	3,141,240	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		11,302	0	11,302	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		59,895	0	59,895	192.00
192.01	19201	FITNESS CENTER	0		156,882	0	156,882	192.01
192.02	19202	RETAIL PHARMACY	0		0	0	0	192.02
192.03	19203	LEASED SPACE	0		14,864	0	14,864	192.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet B
Part II
Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
192.04	19204	VACANT SPACE	0		1,049	0	1,049	192.04
192.05	19205	MEALS ON WHEELS	0		0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0		0	0	0	192.06
200.00		Cross Foot Adjustments		8,232	8,232	0	8,232	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,155	8,232	3,393,464	0	3,393,464	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1

Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW NEW BLDG (SQUARE FEET)	NEW PT BLDG (SQUARE FEET)	203 N WALNUT BLDG (SQUARE FEET)	15 N MAIN BLDG (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	108,254					1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG	0	0				1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG	0	0	3,914			1.02
1.03	00103	CAP REL COSTS-203 N WALNUT BLDG	0	0	0	1,642		1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG	0	0	0	0	0	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,085	0	0	271	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	5,988	0	0	0	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	426	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	852	0	0	0	0	9.00
10.00	01000	DIETARY	4,008	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	418	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,370	0	0	0	0	14.00
15.00	01500	PHARMACY	1,350	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,359	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	95	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,460	0	0	0	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,275	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,545	0	0	0	0	54.00
54.01	05401	ONCOLOGY	2,760	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	296	0	0	0	0	56.00
57.00	05700	CT SCAN	911	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,708	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	2,199	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	6,056	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,523	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	247	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	03950	SENIOR LIFE SOLUTIONS	2,800	0	0	0	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	750	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	845	0	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	10,607	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	337	0	0	0	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	5,883	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100,153	0	0	271	0	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	385	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,012	0	0	0	0	192.00
192.01	19201	FITNESS CENTER	5,204	0	0	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	500	0	0	0	0	192.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1

Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW NEW BLDG (SQUARE FEET)	NEW PT BLDG (SQUARE FEET)	203 N WALNUT BLDG (SQUARE FEET)	15 N MAIN BLDG (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
192.04	19204	VACANT SPACE	0	0	3,914	1,371	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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)	2,792,779	0	17	1,236	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.798391	0.000000	0.004343	0.752741	0.000000	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: 14-1307

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

Worksheet B-1

Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP NEW BLDG (SQUARE FEET)				
			2.00	2.01	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	CAP REL COSTS-203 N WALNUT BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	100,425					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG	0	0				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	12,600,431			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,357	0	1,747,590	-4,417,561	24,711,538	5.00
6.00	00600	MAINTENANCE & REPAIRS	5,988	0	318,953	0	1,269,201	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	426	0	0	0	133,180	8.00
9.00	00900	HOUSEKEEPING	852	0	409,189	0	627,785	9.00
10.00	01000	DIETARY	4,008	0	376,233	0	736,084	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	418	0	727,469	0	1,069,219	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,370	0	33,629	0	88,522	14.00
15.00	01500	PHARMACY	1,350	0	380,965	0	3,135,642	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,359	0	366,376	0	556,730	16.00
17.00	01700	SOCIAL SERVICE	95	0	43,672	0	65,664	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	289,200	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,460	0	1,769,169	0	2,802,425	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,275	0	210,507	0	721,892	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	8,690	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,545	0	501,630	0	1,008,155	54.00
54.01	05401	ONCOLOGY	2,760	0	250,398	0	441,214	54.01
56.00	05600	RADIOISOTOPE	296	0	79,147	0	168,324	56.00
57.00	05700	CT SCAN	911	0	54,749	0	200,365	57.00
58.00	05800	MRI	0	0	0	0	157,729	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,708	0	612,113	0	1,596,964	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	2,199	0	254,841	0	488,241	65.00
66.00	06600	PHYSICAL THERAPY	6,056	0	608,958	0	1,028,900	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,523	0	191,114	0	304,020	67.00
68.00	06800	SPEECH PATHOLOGY	247	0	97,206	0	109,005	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	2,230	0	11,719	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	183,716	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	33,145	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	16,727	0	5,461	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	2,800	0	181,728	0	440,910	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	750	0	0	0	77,826	76.02
76.97	07697	CARDIAC REHABILITATION	845	0	41,758	0	86,038	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	10,607	0	2,710,019	0	4,106,358	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	337	0	5,990	0	166,398	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	19,815	0	29,592	90.01
90.02	04050	TELEMEDICINE	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	5,883	0	534,135	0	2,247,355	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100,425	0	12,546,310	-4,417,561	24,395,669	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	9,932	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	7,722	0	79,163	192.00
192.01	19201	FITNESS CENTER	0	0	46,399	0	213,875	192.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1

Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP NEW BLDG (SQUARE FEET)				
			2.00	2.01	4.00	5A	5.00	
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	12,899	192.03
192.04	19204	VACANT SPACE	0	0	0	-4,194	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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)	599,432	0	4,114,108		4,417,561	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.968952	0.000000	0.326505		0.178765	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		703,407	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.028465	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: 14-1307

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

Worksheet B-1

Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DA YS)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DA YS)	CAFETERIA (SALARIES)	
		6.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG					1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG					1.02
1.03	00103	CAP REL COSTS-203 N WALNUT BLDG					1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	80,181				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	426	2,933			8.00
9.00	00900	HOUSEKEEPING	852	0	4,337		9.00
10.00	01000	DIETARY	4,008	0	359	2,933	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	418	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,370	0	13	0	14.00
15.00	01500	PHARMACY	1,350	0	59	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,359	0	31	0	16.00
17.00	01700	SOCIAL SERVICE	95	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,460	2,933	903	2,933	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,275	0	311	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,545	0	191	0	54.00
54.01	05401	ONCOLOGY	2,760	0	203	0	54.01
56.00	05600	RADIOISOTOPE	296	0	10	0	56.00
57.00	05700	CT SCAN	911	0	31	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	2,708	0	238	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	2,199	0	11	0	65.00
66.00	06600	PHYSICAL THERAPY	6,056	0	237	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,523	0	46	0	67.00
68.00	06800	SPEECH PATHOLOGY	247	0	11	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	03950	SENIOR LIFE SOLUTIONS	2,800	0	136	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	750	0	26	0	76.02
76.97	07697	CARDIAC REHABILITATION	845	0	29	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	10,607	0	580	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	337	0	204	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	0	0	0	0	90.02
91.00	09100	EMERGENCY	5,883	0	541	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	72,080	2,933	4,170	2,933	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	385	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,012	0	0	0	192.00
192.01	19201	FITNESS CENTER	5,204	0	150	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	192.02
192.03	19203	LEASED SPACE	500	0	17	0	192.03
192.04	19204	VACANT SPACE	0	0	0	0	192.04

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1

Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (SALARIES)	
			6.00	8.00	9.00	10.00	11.00	
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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)	1,496,090	164,937	755,908	1,005,026	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.658909	56.234913	174.292829	342.661439	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	226,351	18,527	47,341	163,511	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.823000	6.316741	10.915610	55.748721	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: 14-1307

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

Worksheet B-1

Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description			NURSING ADMINISTRATION (NURSING SA LARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS PATI ENT REVENUE)	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	NEW CAP REL COSTS-NEW BLDG						1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG						1.02
1.03	00103	CAP REL COSTS-203 N WALNUT BLDG						1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	2,565,489					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,078,826				14.00
15.00	01500	PHARMACY	0	1,286	2,510,255			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,807	0	51,982,909		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	2,933	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,613,999	99,648	0	2,080,861	2,933	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	187,901	59,361	0	992,953	0	50.00
53.00	05300	ANESTHESIOLOGY	0	4,953	0	882,463	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47,383	0	3,467,035	0	54.00
54.01	05401	ONCOLOGY	250,398	17,234	0	718,079	0	54.01
56.00	05600	RADIOISOTOPE	0	169	0	727,462	0	56.00
57.00	05700	CT SCAN	0	19,709	0	6,861,457	0	57.00
58.00	05800	MRI	0	229	0	1,335,254	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	398,549	0	9,910,738	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	19,717	0	599,583	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,466	0	3,789,250	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	935	0	1,142,801	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	149,314	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	391	0	369,461	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	228,670	0	602,425	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	33,145	0	119,827	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,510,255	10,333,360	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	2,034	0	407,756	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	599,721	0	76.01
76.02	03030	SLEEP STUDY	0	0	0	367,232	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	496	0	172,460	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	53,238	0	2,933,177	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	462,349	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINC	0	3,307	0	175,711	0	90.01
90.02	04050	TELEMEDICINE	0	0	0	4,514	0	90.02
91.00	09100	EMERGENCY	513,191	75,340	0	2,777,666	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,565,489	1,073,067	2,510,255	51,982,909	2,933	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	1,201	0	0	0	192.00
192.01	19201	FITNESS CENTER	0	4,558	0	0	0	192.01
192.02	19202	RETAIL PHARMACY	0	0	0	0	0	192.02
192.03	19203	LEASED SPACE	0	0	0	0	0	192.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1

Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description			NURSING ADMINISTRATION (NURSING SA LARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS PATI ENT REVENUE)	SOCIAL SERVICE (PATIENT DA YS)	
			13.00	14.00	15.00	16.00	17.00	
192.04	19204	VACANT SPACE	0	0	0	0	0	192.04
192.05	19205	MEALS ON WHEELS	0	0	0	0	0	192.05
192.06	19206	15 N MAIN BUILDING	0	0	0	0	0	192.06
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)	1,268,157	132,176	3,731,816	687,235	79,175	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.494314	0.122518	1.486628	0.013220	26.994545	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	44,894	50,051	136,657	63,277	5,155	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.017499	0.046394	0.054439	0.001217	1.757586	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: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet B-1
Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	NEW CAP REL COSTS-NEW BLDG	1.01
1.02	00102	NEW CAP REL COSTS-PT BLDG	1.02
1.03	00103	CAP REL COSTS-203 N WALNUT BLDG	1.03
1.04	00104	CAP REL COSTS-15 N MAIN BLDG	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP NEW BLDG	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
41.00	04100	SUBPROVIDER - IRF	41.00
42.00	04200	SUBPROVIDER	42.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ONCOLOGY	54.01
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	76.00
76.01	03020	OP IV THERAPY/NURSING	76.01
76.02	03030	SLEEP STUDY	76.02
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
90.00	09000	CLINIC	90.00
90.01	09002	COUMADIN, CHF/COPD CLINC	90.01
90.02	04050	TELEMEDICINE	90.02
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION	109.00
110.00	11000	INTESTINAL ACQUISITION	110.00
111.00	11100	ISLET ACQUISITION	111.00
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	FITNESS CENTER	192.01
192.02	19202	RETAIL PHARMACY	192.02
192.03	19203	LEASED SPACE	192.03
192.04	19204	VACANT SPACE	192.04

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1307

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

Worksheet B-1

Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description			NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
192.05	19205	MEALS ON WHEELS	0	192.05
192.06	19206	15 N MAIN BUILDING	0	192.06
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)	340,899	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3,408.990000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,232	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	82.320000	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

Provider CCN: 14-1307

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

Worksheet B-2

Date/Time Prepared:
9/28/2021 10:59 pm

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0
7.00		RECLASS OP NURSING PROC DONE IN IP		1	76.01	39,807
8.00		RECLASS OP NURSING PROC DONE IN OP		1	30.00	-39,807

Worksheet C
Part I
Date/Time Prepared:
9/28/2021 10:59 pm

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/28/2021 10:59 pm

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,655,100		1,655,100		30.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,156	988,797	992,953	1.199945	50.00
53.00	05300	ANESTHESIOLOGY	3,635	878,828	882,463	0.411819	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	207,852	3,259,183	3,467,035	0.397103	54.00
54.01	05401	ONCOLOGY	0	718,079	718,079	1.033796	54.01
56.00	05600	RADIOISOTOPE	23,875	703,587	727,462	0.295985	56.00
57.00	05700	CT SCAN	254,288	6,607,169	6,861,457	0.051258	57.00
58.00	05800	MRI	55,090	1,280,164	1,335,254	0.152484	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	728,470	9,182,268	9,910,738	0.217371	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	252,702	346,881	599,583	1.048747	65.00
66.00	06600	PHYSICAL THERAPY	446,304	3,342,946	3,789,250	0.374190	66.00
67.00	06700	OCCUPATIONAL THERAPY	328,677	814,124	1,142,801	0.358790	67.00
68.00	06800	SPEECH PATHOLOGY	33,094	116,220	149,314	0.917469	68.00
69.00	06900	ELECTROCARDIOLOGY	13,196	356,265	369,461	0.050739	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	426,456	175,969	602,425	0.419202	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	119,827	119,827	0.373163	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	925,711	9,407,649	10,333,360	0.374988	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	407,756	407,756	1.474701	76.00
76.01	03020	OP IV THERAPY/NURSING	0	599,721	599,721	0.079595	76.01
76.02	03030	SLEEP STUDY	0	367,232	367,232	0.313480	76.02
76.97	07697	CARDIAC REHABILITATION	0	172,460	172,460	0.722376	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,933,177	2,933,177		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	6,924	455,425	462,349	0.527956	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	175,711	175,711	0.214045	90.01
90.02	04050	TELEMEDICINE	0	4,514	4,514	0.013292	90.02
91.00	09100	EMERGENCY	130,533	2,647,133	2,777,666	1.135052	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	425,761	425,761	1.669084	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	5,496,063	46,486,846	51,982,909		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	5,496,063	46,486,846	51,982,909		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
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
54.01	05401	ONCOLOGY	0.000000			54.01
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
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
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	03950	SENIOR LIFE SOLUTIONS	0.000000			76.00
76.01	03020	OP IV THERAPY/NURSING	0.000000			76.01
76.02	03030	SLEEP STUDY	0.000000			76.02
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0.000000			90.00
90.01	09002	COUMADIN, CHF/COPD CLINC	0.000000			90.01
90.02	04050	TELEMEDICINE	0.000000			90.02
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
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

Health Financial Systems		PINCKNEYVILLE COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-1307	Period: From 05/01/2020 To 04/30/2021	Worksheet C Part I Date/Time Prepared: 9/28/2021 10:59 pm
			Title XIX	Hospital	Cost
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs	
				Total Costs	Total Costs
		1.00	2.00	3.00	4.00
					5.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,684,174	5,684,174	5,684,174
41.00	04100	SUBPROVIDER - IRF	0	0	0
42.00	04200	SUBPROVIDER	0	0	0
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,191,489	1,191,489	1,191,489
53.00	05300	ANESTHESIOLOGY	363,415	363,415	363,415
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,376,771	1,376,771	1,376,771
54.01	05401	ONCOLOGY	742,347	742,347	742,347
56.00	05600	RADIOISOTOPE	215,318	215,318	215,318
57.00	05700	CT SCAN	351,707	351,707	351,707
58.00	05800	MRI	203,605	203,605	203,605
59.00	05900	CARDIAC CATHETERIZATION	0	0	0
60.00	06000	LABORATORY	2,154,303	2,154,303	2,154,303
60.01	06001	BLOOD LABORATORY	0	0	0
65.00	06500	RESPIRATORY THERAPY	628,811	628,811	628,811
66.00	06600	PHYSICAL THERAPY	1,417,900	1,417,900	1,417,900
67.00	06700	OCCUPATIONAL THERAPY	410,026	410,026	410,026
68.00	06800	SPEECH PATHOLOGY	136,991	136,991	136,991
69.00	06900	ELECTROCARDIOLOGY	18,746	18,746	18,746
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	252,538	252,538	252,538
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,715	44,715	44,715
73.00	07300	DRUGS CHARGED TO PATIENTS	3,874,881	3,874,881	3,874,881
76.00	03950	SENIOR LIFE SOLUTIONS	601,318	601,318	601,318
76.01	03020	OP IV THERAPY/NURSING	47,735	47,735	47,735
76.02	03030	SLEEP STUDY	115,120	115,120	115,120
76.97	07697	CARDIAC REHABILITATION	124,581	124,581	124,581
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	5,184,741	5,184,741	5,184,741
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0
90.00	09000	CLINIC	244,100	244,100	244,100
90.01	09002	COUMADIN, CHF/COPD CLINIC	37,610	37,610	37,610
90.02	04050	TELEMEDICINE	60	60	60
91.00	09100	EMERGENCY	3,152,794	3,152,794	3,152,794
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	710,631	710,631	710,631
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	0
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0
113.00	11300	INTEREST EXPENSE			
200.00		Subtotal (see instructions)	29,286,427	29,286,427	29,286,427
201.00		Less Observation Beds	710,631	710,631	710,631
202.00		Total (see instructions)	28,575,796	28,575,796	28,575,796

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/28/2021 10:59 pm

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,655,100		1,655,100		30.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,156	988,797	992,953	1.199945	50.00
53.00	05300	ANESTHESIOLOGY	3,635	878,828	882,463	0.411819	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	207,852	3,259,183	3,467,035	0.397103	54.00
54.01	05401	ONCOLOGY	0	718,079	718,079	1.033796	54.01
56.00	05600	RADIOISOTOPE	23,875	703,587	727,462	0.295985	56.00
57.00	05700	CT SCAN	254,288	6,607,169	6,861,457	0.051258	57.00
58.00	05800	MRI	55,090	1,280,164	1,335,254	0.152484	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	728,470	9,182,268	9,910,738	0.217371	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	252,702	346,881	599,583	1.048747	65.00
66.00	06600	PHYSICAL THERAPY	446,304	3,342,946	3,789,250	0.374190	66.00
67.00	06700	OCCUPATIONAL THERAPY	328,677	814,124	1,142,801	0.358790	67.00
68.00	06800	SPEECH PATHOLOGY	33,094	116,220	149,314	0.917469	68.00
69.00	06900	ELECTROCARDIOLOGY	13,196	356,265	369,461	0.050739	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	426,456	175,969	602,425	0.419202	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	119,827	119,827	0.373163	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	925,711	9,407,649	10,333,360	0.374988	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	407,756	407,756	1.474701	76.00
76.01	03020	OP IV THERAPY/NURSING	0	599,721	599,721	0.079595	76.01
76.02	03030	SLEEP STUDY	0	367,232	367,232	0.313480	76.02
76.97	07697	CARDIAC REHABILITATION	0	172,460	172,460	0.722376	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,933,177	2,933,177	1.767620	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	6,924	455,425	462,349	0.527956	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	175,711	175,711	0.214045	90.01
90.02	04050	TELEMEDICINE	0	4,514	4,514	0.013292	90.02
91.00	09100	EMERGENCY	130,533	2,647,133	2,777,666	1.135052	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	425,761	425,761	1.669084	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	5,496,063	46,486,846	51,982,909		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	5,496,063	46,486,846	51,982,909		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet C
Part I
Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
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
54.01	05401	ONCOLOGY	0.000000			54.01
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
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
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	03950	SENIOR LIFE SOLUTIONS	0.000000			76.00
76.01	03020	OP IV THERAPY/NURSING	0.000000			76.01
76.02	03030	SLEEP STUDY	0.000000			76.02
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90.00	09000	CLINIC	0.000000			90.00
90.01	09002	COUMADIN, CHF/COPD CLINC	0.000000			90.01
90.02	04050	TELEMEDICINE	0.000000			90.02
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
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: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part II
Date/Time Prepared:
9/28/2021 10:59 pm

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	352,019	992,953	0.354517	0	50.00
53.00	05300	ANESTHESIOLOGY	1,551	882,463	0.001758	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	229,003	3,467,035	0.066052	86,328	54.00
54.01	05401	ONCOLOGY	116,300	718,079	0.161960	0	54.01
56.00	05600	RADIOISOTOPE	16,032	727,462	0.022038	12,716	56.00
57.00	05700	CT SCAN	46,817	6,861,457	0.006823	102,479	57.00
58.00	05800	MRI	6,126	1,335,254	0.004588	18,328	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	59.00
60.00	06000	LABORATORY	172,278	9,910,738	0.017383	279,603	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	91,728	599,583	0.152986	161,484	65.00
66.00	06600	PHYSICAL THERAPY	246,220	3,789,250	0.064979	35,020	66.00
67.00	06700	OCCUPATIONAL THERAPY	63,271	1,142,801	0.055365	31,317	67.00
68.00	06800	SPEECH PATHOLOGY	11,948	149,314	0.080019	5,883	68.00
69.00	06900	ELECTROCARDIOLOGY	802	369,461	0.002171	7,280	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,571	602,425	0.027507	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,627	119,827	0.021923	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	149,402	10,333,360	0.014458	231,859	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	111,478	407,756	0.273394	0	76.00
76.01	03020	OP IV THERAPY/NURSING	730	599,721	0.001217	0	76.01
76.02	03030	SLEEP STUDY	28,889	367,232	0.078667	0	76.02
76.97	07697	CARDIAC REHABILITATION	32,228	172,460	0.186872	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	496,152	2,933,177	0.169152	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	89.00
90.00	09000	CLINIC	19,184	462,349	0.041492	617	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	1,209	175,711	0.006881	0	90.01
90.02	04050	TELEMEDICINE	5	4,514	0.001108	0	90.02
91.00	09100	EMERGENCY	289,226	2,777,666	0.104126	451	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	79,943	425,761	0.187765	0	92.00
200.00		Total (lines 50 through 199)	2,581,739	50,327,809		973,365	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part IV
Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	340,899	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ONCOLOGY	0	0	0	0	0	54.01
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
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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	03950	SENIOR LIFE SOLUTIONS	0	0	0	0	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	0	0	76.01
76.02	03030	SLEEP STUDY	0	0	0	0	0	76.02
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
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINC	0	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	0	0	0	0	0	90.02
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)	340,899	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part IV
Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			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	992,953	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	340,899	0	882,463	0.386304	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,467,035	0.000000	54.00
54.01	05401	ONCOLOGY	0	0	0	718,079	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	727,462	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	6,861,457	0.000000	57.00
58.00	05800	MRI	0	0	0	1,335,254	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	9,910,738	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	599,583	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,789,250	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,142,801	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	149,314	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	369,461	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	602,425	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	119,827	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,333,360	0.000000	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	0	0	407,756	0.000000	76.00
76.01	03020	OP IV THERAPY/NURSING	0	0	0	599,721	0.000000	76.01
76.02	03030	SLEEP STUDY	0	0	0	367,232	0.000000	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	172,460	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,933,177	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	462,349	0.000000	90.00
90.01	09002	COUMADIN, CHF/COPD CLINC	0	0	0	175,711	0.000000	90.01
90.02	04050	TELEMEDICINE	0	0	0	4,514	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	2,777,666	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	425,761	0.000000	92.00
200.00		Total (lines 50 through 199)	0	340,899	0	50,327,809		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part IV
Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description			Title XVIII		Hospital		Cost
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	86,328	0	0	0 54.00
54.01	05401	ONCOLOGY	0.000000	0	0	0	0 54.01
56.00	05600	RADIOISOTOPE	0.000000	12,716	0	0	0 56.00
57.00	05700	CT SCAN	0.000000	102,479	0	0	0 57.00
58.00	05800	MRI	0.000000	18,328	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00	06000	LABORATORY	0.000000	279,603	0	0	0 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	161,484	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	35,020	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	31,317	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	5,883	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,280	0	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	231,859	0	0	0 73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0.000000	0	0	0	0 76.00
76.01	03020	OP IV THERAPY/NURSING	0.000000	0	0	0	0 76.01
76.02	03030	SLEEP STUDY	0.000000	0	0	0	0 76.02
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
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0 89.00
90.00	09000	CLINIC	0.000000	617	0	0	0 90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0.000000	0	0	0	0 90.01
90.02	04050	TELEMEDICINE	0.000000	0	0	0	0 90.02
91.00	09100	EMERGENCY	0.000000	451	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0 92.00
200.00		Total (lines 50 through 199)		973,365	0	0	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part V
Date/Time Prepared:
9/28/2021 10:59 pm

			Title XVIII		Hospital		Cost	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1.199945	0	460,850	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.411819	0	382,050	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.397103	0	1,326,019	0	0	54.00
54.01	05401	ONCOLOGY	1.033796	0	218,527	0	0	54.01
56.00	05600	RADIOISOTOPE	0.295985	0	350,725	0	0	56.00
57.00	05700	CT SCAN	0.051258	0	2,957,578	0	0	57.00
58.00	05800	MRI	0.152484	0	574,492	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.217371	0	4,092,284	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1.048747	0	171,327	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.374190	0	1,361,356	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.358790	0	235,201	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.917469	0	21,091	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.050739	0	169,260	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.419202	0	66,433	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.373163	0	26,405	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.374988	0	5,674,126	701	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	1.474701	0	405,708	0	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0.079595	0	406,265	0	0	76.01
76.02	03030	SLEEP STUDY	0.313480	0	130,084	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.722376	0	113,700	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.527956	0	404,199	0	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0.214045	0	105,793	0	0	90.01
90.02	04050	TELEMEDICINE	0.013292	0	0	0	0	90.02
91.00	09100	EMERGENCY	1.135052	0	1,001,137	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.669084	0	244,879	0	0	92.00
200.00		Subtotal (see instructions)		0	20,899,489	701	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	20,899,489	701	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part V
Date/Time Prepared:
9/28/2021 10:59 pm

			Title XVIII		Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	552,995	0		50.00
53.00	05300	ANESTHESIOLOGY	157,335	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	526,566	0		54.00
54.01	05401	ONCOLOGY	225,912	0		54.01
56.00	05600	RADIOISOTOPE	103,809	0		56.00
57.00	05700	CT SCAN	151,600	0		57.00
58.00	05800	MRI	87,601	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	889,544	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	179,679	0		65.00
66.00	06600	PHYSICAL THERAPY	509,406	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	84,388	0		67.00
68.00	06800	SPEECH PATHOLOGY	19,350	0		68.00
69.00	06900	ELECTROCARDIOLOGY	8,588	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,849	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,853	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,127,729	263		73.00
76.00	03950	SENIOR LIFE SOLUTIONS	598,298	0		76.00
76.01	03020	OP IV THERAPY/NURSING	32,337	0		76.01
76.02	03030	SLEEP STUDY	40,779	0		76.02
76.97	07697	CARDIAC REHABILITATION	82,134	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	213,399	0		90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	22,644	0		90.01
90.02	04050	TELEMEDICINE	0	0		90.02
91.00	09100	EMERGENCY	1,136,343	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	408,724	0		92.00
200.00		Subtotal (see instructions)	8,196,862	263		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	8,196,862	263		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1307

Period:

Worksheet D

Component CCN: 14-Z307

From 05/01/2020
To 04/30/2021Part V
Date/Time Prepared:
9/28/2021 10:59 pm

			Title XVIII	Swing Beds - SNF		Cost	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.199945	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.411819	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.397103	0	0	0	54.00
54.01	05401	ONCOLOGY	1.033796	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.295985	0	0	0	56.00
57.00	05700	CT SCAN	0.051258	0	0	0	57.00
58.00	05800	MRI	0.152484	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000	LABORATORY	0.217371	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1.048747	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.374190	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.358790	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.917469	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.050739	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.419202	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.373163	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.374988	0	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	1.474701	0	0	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0.079595	0	0	0	76.01
76.02	03030	SLEEP STUDY	0.313480	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.722376	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC					88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER					89.00
90.00	09000	CLINIC	0.527956	0	0	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0.214045	0	0	0	90.01
90.02	04050	TELEMEDICINE	0.013292	0	0	0	90.02
91.00	09100	EMERGENCY	1.135052	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.669084	0	0	0	92.00
200.00		Subtotal (see instructions)		0	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	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1307

Period:

Worksheet D

Component CCN: 14-Z307

From 05/01/2020
To 04/30/2021Part V
Date/Time Prepared:
9/28/2021 10:59 pm

			Title XVIII		Swing Beds - SNF		Cost	
Cost Center Description			Costs					
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
			6.00	7.00				
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0			50.00	
53.00	05300	ANESTHESIOLOGY	0	0			53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0			54.00	
54.01	05401	ONCOLOGY	0	0			54.01	
56.00	05600	RADIOISOTOPE	0	0			56.00	
57.00	05700	CT SCAN	0	0			57.00	
58.00	05800	MRI	0	0			58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0			59.00	
60.00	06000	LABORATORY	0	0			60.00	
60.01	06001	BLOOD LABORATORY	0	0			60.01	
65.00	06500	RESPIRATORY THERAPY	0	0			65.00	
66.00	06600	PHYSICAL THERAPY	0	0			66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0			67.00	
68.00	06800	SPEECH PATHOLOGY	0	0			68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0			69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0			70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0			73.00	
76.00	03950	SENIOR LIFE SOLUTIONS	0	0			76.00	
76.01	03020	OP IV THERAPY/NURSING	0	0			76.01	
76.02	03030	SLEEP STUDY	0	0			76.02	
76.97	07697	CARDIAC REHABILITATION	0	0			76.97	
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC					88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER					89.00	
90.00	09000	CLINIC	0	0			90.00	
90.01	09002	COUMADIN, CHF/COPD CLINIC	0	0			90.01	
90.02	04050	TELEMEDICINE	0	0			90.02	
91.00	09100	EMERGENCY	0	0			91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0			92.00	
200.00		Subtotal (see instructions)	0	0			200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0				201.00	
202.00		Net Charges (line 200 - line 201)	0	0			202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part V
Date/Time Prepared:
9/28/2021 10:59 pm

			Title XIX		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	1.199945	0	33,203	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.411819	0	22,314	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.397103	0	443,079	0	0	54.00
54.01	05401	ONCOLOGY	1.033796	0	81,020	0	0	54.01
56.00	05600	RADIOISOTOPE	0.295985	0	45,341	0	0	56.00
57.00	05700	CT SCAN	0.051258	0	982,227	0	0	57.00
58.00	05800	MRI	0.152484	0	134,392	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.217371	0	1,172,519	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1.048747	0	45,710	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.374190	0	217,674	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.358790	0	98,149	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.917469	0	30,898	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.050739	0	37,485	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.419202	0	20,189	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.373163	0	927	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.374988	0	1,228,407	0	0	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	1.474701	0	0	0	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0.079595	0	110,490	0	0	76.01
76.02	03030	SLEEP STUDY	0.313480	0	44,128	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.722376	0	19,077	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.527956	0	19,800	0	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0.214045	0	0	0	0	90.01
90.02	04050	TELEMEDICINE	0.013292	0	76	0	0	90.02
91.00	09100	EMERGENCY	1.135052	0	601,737	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.669084	0	73,962	0	0	92.00
200.00		Subtotal (see instructions)		0	5,462,804	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	5,462,804	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet D
Part V
Date/Time Prepared:
9/28/2021 10:59 pm

			Title XIX		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	39,842	0		50.00
53.00	05300	ANESTHESIOLOGY	9,189	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	175,948	0		54.00
54.01	05401	ONCOLOGY	83,758	0		54.01
56.00	05600	RADIOISOTOPE	13,420	0		56.00
57.00	05700	CT SCAN	50,347	0		57.00
58.00	05800	MRI	20,493	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	254,872	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	47,938	0		65.00
66.00	06600	PHYSICAL THERAPY	81,451	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	35,215	0		67.00
68.00	06800	SPEECH PATHOLOGY	28,348	0		68.00
69.00	06900	ELECTROCARDIOLOGY	1,902	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,463	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	346	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	460,638	0		73.00
76.00	03950	SENIOR LIFE SOLUTIONS	0	0		76.00
76.01	03020	OP IV THERAPY/NURSING	8,794	0		76.01
76.02	03030	SLEEP STUDY	13,833	0		76.02
76.97	07697	CARDIAC REHABILITATION	13,781	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	10,454	0		90.00
90.01	09002	COUMADIN, CHF/COPD CLINC	0	0		90.01
90.02	04050	TELEMEDICINE	1	0		90.02
91.00	09100	EMERGENCY	683,003	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	123,449	0		92.00
200.00		Subtotal (see instructions)	2,165,485	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,165,485	0		202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1307

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

Worksheet D-1

Date/Time Prepared:
9/28/2021 10:59 pm

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)			3,255 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,174 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)			852 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			946 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)			400 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			433 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)			302 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			504 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)			850 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)			369 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			164.92 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			169.87 20.00
21.00	Total general inpatient routine service cost (see instructions)			5,684,174 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)			71,410 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)			51,301 25.00
26.00	Total swing-bed cost (see instructions)			3,093,239 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,590,935 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)			2,590,935 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			2,206.93 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,112,293 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,112,293 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1307

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

Worksheet D-1

Date/Time Prepared:
9/28/2021 10:59 pm

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						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)					394,115	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,506,408	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)					1,875,891	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					814,357	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					2,690,248	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)					322	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,206.93	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					710,631	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1307

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

Worksheet D-1

Date/Time Prepared:
9/28/2021 10:59 pm

		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	639,444	5,684,174	0.112496	710,631	79,943	90.00
91.00	Nursing School cost	0	5,684,174	0.000000	710,631	0	91.00
92.00	Allied health cost	0	5,684,174	0.000000	710,631	0	92.00
93.00	All other Medical Education	0	5,684,174	0.000000	710,631	0	93.00

Health Financial Systems		PINCKNEYVILLE COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1307	Period: From 05/01/2020 To 04/30/2021	Worksheet D-3 Date/Time Prepared: 9/28/2021 10:59 pm
			Title XVIII	Hospital	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		598,301	30.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1.199945	0	50.00
53.00	05300	ANESTHESIOLOGY	0.411819	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.397103	86,328	54.00
54.01	05401	ONCOLOGY	1.033796	0	54.01
56.00	05600	RADIOISOTOPE	0.295985	12,716	56.00
57.00	05700	CT SCAN	0.051258	102,479	57.00
58.00	05800	MRI	0.152484	18,328	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.217371	279,603	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	1.048747	161,484	65.00
66.00	06600	PHYSICAL THERAPY	0.374190	35,020	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.358790	31,317	67.00
68.00	06800	SPEECH PATHOLOGY	0.917469	5,883	68.00
69.00	06900	ELECTROCARDIOLOGY	0.050739	7,280	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.419202	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.373163	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.374988	231,859	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	1.474701	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0.079595	0	76.01
76.02	03030	SLEEP STUDY	0.313480	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.722376	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.527956	617	90.00
90.01	09002	COUMADIN, CHF/COPD CLINC	0.214045	0	90.01
90.02	04050	TELEMEDICINE	0.013292	0	90.02
91.00	09100	EMERGENCY	1.135052	451	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.669084	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		973,365	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)		973,365	202.00

Health Financial Systems		PINCKNEYVILLE COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1307	Period: From 05/01/2020	Worksheet D-3	
		Component CCN: 14-Z307	To 04/30/2021	Date/Time Prepared: 9/28/2021 10:59 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1.199945	2,290	50.00
53.00	05300	ANESTHESIOLOGY	0.411819	1,541	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.397103	62,386	54.00
54.01	05401	ONCOLOGY	1.033796	0	54.01
56.00	05600	RADIOISOTOPE	0.295985	4,360	56.00
57.00	05700	CT SCAN	0.051258	91,592	57.00
58.00	05800	MRI	0.152484	30,379	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.217371	230,090	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	1.048747	91,058	65.00
66.00	06600	PHYSICAL THERAPY	0.374190	356,635	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.358790	251,162	67.00
68.00	06800	SPEECH PATHOLOGY	0.917469	22,820	68.00
69.00	06900	ELECTROCARDIOLOGY	0.050739	2,502	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.419202	203,397	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.373163	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.374988	313,101	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	1.474701	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0.079595	0	76.01
76.02	03030	SLEEP STUDY	0.313480	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.722376	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	0.527956	6,307	90.00
90.01	09002	COUMADIN, CHF/COPD CLINIC	0.214045	0	90.01
90.02	04050	TELEMEDICINE	0.013292	0	90.02
91.00	09100	EMERGENCY	1.135052	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.669084	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,669,620	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)		1,669,620	202.00

Health Financial Systems		PINCKNEYVILLE COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1307	Period: From 05/01/2020 To 04/30/2021	Worksheet D-3 Date/Time Prepared: 9/28/2021 10:59 pm
			Title XIX	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		37,926	30.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1.199945	0	50.00
53.00	05300	ANESTHESIOLOGY	0.411819	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.397103	3,590	54.00
54.01	05401	ONCOLOGY	1.033796	0	54.01
56.00	05600	RADIOISOTOPE	0.295985	0	56.00
57.00	05700	CT SCAN	0.051258	12,444	57.00
58.00	05800	MRI	0.152484	5,991	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.217371	9,671	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	1.048747	160	65.00
66.00	06600	PHYSICAL THERAPY	0.374190	832	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.358790	892	67.00
68.00	06800	SPEECH PATHOLOGY	0.917469	421	68.00
69.00	06900	ELECTROCARDIOLOGY	0.050739	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.419202	1,066	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.373163	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.374988	11,898	73.00
76.00	03950	SENIOR LIFE SOLUTIONS	1.474701	0	76.00
76.01	03020	OP IV THERAPY/NURSING	0.079595	0	76.01
76.02	03030	SLEEP STUDY	0.313480	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.722376	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1.767620	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	0.527956	0	90.00
90.01	09002	COUMADIN, CHF/COPD CLINC	0.214045	0	90.01
90.02	04050	TELEMEDICINE	0.013292	0	90.02
91.00	09100	EMERGENCY	1.135052	12,355	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.669084	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		59,320	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)		59,320	202.00

Health Financial Systems		PINCKNEYVILLE COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1307	Period: From 05/01/2020 To 04/30/2021	Worksheet E Part B Date/Time Prepared: 9/28/2021 10:59 pm	
		Title XVIII	Hospital	Cost	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)		8,197,125	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)		8,197,125	11.00	
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges		0	12.00	
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00	
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00	
Customary charges					
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00	
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00	
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00	
18.00	Total customary charges (see instructions)		0	18.00	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00	
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00	
21.00	Lesser of cost or charges (see instructions)		8,279,096	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)		34,965	25.00	
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,334,369	26.00	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		4,909,762	27.00	
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00	
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00	
30.00	Subtotal (sum of lines 27 through 29)		4,909,762	30.00	
31.00	Primary payer payments		5,108	31.00	
32.00	Subtotal (line 30 minus line 31)		4,904,654	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)		248,311	34.00	
35.00	Adjusted reimbursable bad debts (see instructions)		161,402	35.00	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		120,832	36.00	
37.00	Subtotal (see instructions)		5,066,056	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)			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)		5,066,056	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			40.03	
41.00	Interim payments		6,049,016	41.00	
41.01	Interim payments-PARHM			41.01	
42.00	Tentative settlement (for contractors use only)		0	42.00	
42.01	Tentative settlement-PARHM (for contractor use only)			42.01	
43.00	Balance due provider/program (see instructions)		-982,960	43.00	
43.01	Balance due provider/program-PARHM (see instructions)			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)			93.00	
94.00	Total (sum of lines 91 and 93)		0	94.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet E-1
Part I
Date/Time Prepared:
9/28/2021 10:59 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,267,231		5,384,461	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	07/28/2020	14,589	07/28/2020	25,380	3.01
3.02			0	12/28/2020	187,435	3.02
3.03			0	04/23/2021	451,740	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	12/28/2020	38,554		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)		-23,965		664,555	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,243,266		6,049,016	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		134,400		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		982,960	6.02
7.00	Total Medicare program liability (see instructions)		1,377,666		5,066,056	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES, INC.		06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1307

Period:

Worksheet E-1

Component CCN: 14-Z307

From 05/01/2020
To 04/30/2021Part I
Date/Time Prepared:
9/28/2021 10:59 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,163,925		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	07/28/2020	7,091		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	12/28/2020	40,655		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)		-33,564		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)		3,130,361		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		171,183		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,301,544		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES, INC.		06101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet E-1
Part II
Date/Time Prepared:
9/28/2021 10:59 pm

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

Health Financial Systems		PINCKNEYVILLE COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1307	Period: From 05/01/2020 To 04/30/2021	Worksheet E-2	
		Component CCN: 14-Z307		Date/Time Prepared: 9/28/2021 10:59 pm	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		2,717,150	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)		641,265	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		1,219	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)		3,358,415	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		3,358,415	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)		3,358,415	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		56,871	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		3,301,544	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)		3,301,544	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		3,130,361	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)		171,183	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: 14-1307	Period: From 05/01/2020 To 04/30/2021	Worksheet E-3 Part V Date/Time Prepared: 9/28/2021 10:59 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,506,408	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)		1,506,408	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,521,472	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)		1,521,472	19.00
20.00	Deductibles (exclude professional component)		159,252	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,362,220	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,362,220	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		23,763	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		15,446	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		13,253	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,377,666	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		1,377,666	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		0	30.03
31.00	Interim payments		1,243,266	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		134,400	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	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: 14-1307

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

Worksheet G

Date/Time Prepared:
9/28/2021 10:59 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	23,326,791	0	0	0	1.00
2.00 Temporary investments	25,051	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	3,446,825	0	0	0	4.00
5.00 Other receivable	577,274	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	314,495	0	0	0	7.00
8.00 Prepaid expenses	307,533	0	0	0	8.00
9.00 Other current assets	1,097,169	0	0	47,224	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	29,095,138	0	0	47,224	11.00
FIXED ASSETS					
12.00 Land	422,113	0	0	0	12.00
13.00 Land improvements	3,380,441	0	0	0	13.00
14.00 Accumulated depreciation	-1,047,090	0	0	0	14.00
15.00 Buildings	35,279,625	0	0	0	15.00
16.00 Accumulated depreciation	-8,807,897	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	5,940,062	0	0	0	23.00
24.00 Accumulated depreciation	-4,131,926	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	1,682,323	0	0	0	27.00
28.00 Accumulated depreciation	-1,682,323	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	31,035,328	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	3,188,665	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	3,188,665	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	63,319,131	0	0	47,224	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	569,073	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,080,721	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	425,000	0	0	0	40.00
41.00 Deferred income	282,550	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	10,441,521	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	12,798,865	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	23,550,179	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	0	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	23,550,179	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	36,349,044	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	26,970,087	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	47,224	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	26,970,087	0	0	47,224	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	63,319,131	0	0	47,224	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1307

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

Worksheet G-1

Date/Time Prepared:
9/28/2021 10:59 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		22,940,517		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,027,588				2.00
3.00	Total (sum of line 1 and line 2)		26,968,105		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	TRANSFER	1,982		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		1,982		0		10.00
11.00	Subtotal (line 3 plus line 10)		26,970,087		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	TRANSFER	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)		26,970,087		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		49,206			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		49,206			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	TRANSFER		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		49,206			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	TRANSFER		1,982				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		1,982			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		47,224			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1307

Period:
From 05/01/2020
To 04/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
9/28/2021 10:59 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	986,239		986,239	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	668,861		668,861	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)	1,655,100		1,655,100	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,655,100		1,655,100	17.00
18.00	Ancillary services	3,681,881	39,866,750	43,548,631	18.00
19.00	Outpatient services	137,104	3,708,897	3,846,001	19.00
20.00	RURAL HEALTH CLINIC	0	2,933,177	2,933,177	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	70,527	1,675,263	1,745,790	27.00
27.01	340 GROSS UP	0	0	0	27.01
27.02	RHC CHRONIC & TRANSITIONAL CARE	0	0	0	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,544,612	48,184,087	53,728,699	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,260,524		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BAD DEBT EXPENSE	153,586			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)		153,586		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)		31,414,110		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1307

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

Worksheet G-3

Date/Time Prepared:
9/28/2021 10:59 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	53,728,699	1.00
2.00	Less contractual allowances and discounts on patients' accounts	22,575,156	2.00
3.00	Net patient revenues (line 1 minus line 2)	31,153,543	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,414,110	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-260,567	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	31,341	6.00
7.00	Income from investments	169,927	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	21,240	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	65,674	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	5,780	17.00
18.00	Revenue from sale of medical records and abstracts	4,060	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	40,440	22.00
23.00	Governmental appropriations	1,672,148	23.00
24.00	CONTRACT SERVICES	71,463	24.00
24.01	MISC OPERATING REVENUE	650,657	24.01
24.02	MISC NON-OPERATING REVENUE	-167,678	24.02
24.03	340B DISCOUNT	1,723,103	24.03
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	4,288,155	25.00
26.00	Total (line 5 plus line 25)	4,027,588	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)	4,027,588	29.00

Health Financial Systems		PINCKNEYVILLE COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-10		
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS				Provider CCN: 14-1307	Period: From 05/01/2020	Worksheet M-1	
				Component CCN: 14-3412	To 04/30/2021	Date/Time Prepared: 9/28/2021 10:59 pm	
				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	1,244,431	64,262	1,308,693	-146,980	1,161,713	1.00
2.00	Physician Assistant	292,120	0	292,120	-5,228	286,892	2.00
3.00	Nurse Practitioner	180,988	0	180,988	-82	180,906	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	481,144	0	481,144	-55,103	426,041	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	0	11,158	11,158	-3,385	7,773	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,198,683	75,420	2,274,103	-210,778	2,063,325	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	155,946	155,946	-102,080	53,866	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	104,609	104,609	0	104,609	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	260,555	260,555	-102,080	158,475	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,198,683	335,975	2,534,658	-312,858	2,221,800	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	21,813	21,813	25.01
25.02	Chronic Care Management	0	0	0	7,081	7,081	25.02
26.00	All other nonreimbursable costs	0	0	0	32,888	32,888	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	61,782	61,782	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	650,929	35,683	686,612	0	686,612	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	650,929	35,683	686,612	0	686,612	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,849,612	371,658	3,221,270	-251,076	2,970,194	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1307

Period:

Worksheet M-1

Component CCN: 14-3412

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/28/2021 10:59 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-84,474	1,077,239	1.00
2.00	Physician Assistant	0	286,892	2.00
3.00	Nurse Practitioner	0	180,906	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	426,041	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	7,773	9.00
10.00	Subtotal (sum of lines 1 through 9)	-84,474	1,978,851	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	53,866	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	104,609	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	158,475	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-84,474	2,137,326	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	21,813	25.01
25.02	Chronic Care Management	0	7,081	25.02
26.00	All other nonreimbursable costs	0	32,888	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	61,782	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-1,156	685,456	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,156	685,456	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-85,630	2,884,564	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1307

Period:

Worksheet M-2

Component CCN: 14-3412

From 05/01/2020
To 04/30/2021Date/Time Prepared:
9/28/2021 10:59 pm

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	2.56	8,938	4,200	10,752	1.00
2.00	Physician Assistant	1.59	3,419	2,100	3,339	2.00
3.00	Nurse Practitioner	1.66	2,728	2,100	3,486	3.00
4.00	Subtotal (sum of lines 1 through 3)	5.81	15,085		17,577	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)	5.81	15,085		17,577	8.00
9.00	Physician Services Under Agreements		249		249	9.00
						1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				2,137,326	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				61,782	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				2,199,108	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.971906	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				685,456	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				2,300,177	15.00
16.00	Total overhead (sum of lines 14 and 15)				2,985,633	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				2,985,633	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				2,901,755	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				5,039,081	20.00

Health Financial Systems		PINCKNEYVILLE COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1307	Period: From 05/01/2020 To 04/30/2021	Worksheet M-3		
		Component CCN: 14-3412		Date/Time Prepared: 9/28/2021 10:59 pm		
		Title XVIII	RHC I	Cost		
			1.00			
1.00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			5,039,081	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			143,816	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			4,895,265	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			17,577	4.00	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			249	5.00	
6.00	Total adjusted visits (line 4 plus line 5)			17,826	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			274.61	7.00	
		Calculation of Limit (1)				
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)		
		1.00	2.00	3.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		86.31	87.52	249.80	8.00
9.00	Rate for Program covered visits (see instructions)		274.61	274.61	274.61	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		3,782	1,418	473	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		1,038,575	389,397	129,891	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	1,557,863		16.00
16.01	Total program charges (see instructions)(from contractor's records)			965,335		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			52,370		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			84,516		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.)			1,116,713		16.04
16.05	Total program cost (see instructions)		0	1,201,229		16.05
17.00	Primary payer amounts			0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			77,456		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			167,102		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			1,201,229		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			74,607		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			1,275,836		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)			1,275,836		26.00
26.01	Sequestration adjustment (see instructions)			0		26.01
26.02	Demonstration payment adjustment amount after sequestration			0		26.02
27.00	Interim payments			1,062,292		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)			213,544		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1307 Component CCN: 14-3412	Period: From 05/01/2020 To 04/30/2021	Worksheet M-4 Date/Time Prepared: 9/28/2021 10:59 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,978,851	1,978,851	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000685	0.002941	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,356	5,820	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		26,712	27,112	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		28,068	32,932	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,137,326	2,137,326	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,901,755	2,901,755	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.013132	0.015408	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		38,106	44,710	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		66,174	77,642	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		186	798	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		355.77	97.30	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		88	445	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		31,308	43,299	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			143,816	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			74,607	16.00

Health Financial Systems		PINCKNEYVILLE COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1307 Component CCN: 14-3412	Period: From 05/01/2020 To 04/30/2021	Worksheet M-5 Date/Time Prepared: 9/28/2021 10:59 pm	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,081,529	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		07/28/2020	3,666		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50		12/28/2020	22,903		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)		-19,237		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,062,292		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		213,544		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		1,275,836		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES, INC.	06101		8.00