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

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1304	Period: From 07/01/2022 To 06/30/2023	Worksheet S Parts I-III Date/Time Prepared: 11/28/2023 8:47 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/28/2023 Time: 8:47 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GENESIS MEDICAL CENTER - ALEDO (14-1304) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Joseph Malas		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Joseph Malas			2
3	Signatory Title	CHIEF FINANCAIL OFFICER			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-47,768	32,665	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	-20,957	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-24,380		0	10.00
200.00	TOTAL	0	-68,725	8,285	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2023 8:47 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 409 NW NINTH AVENUE	PO Box:			1.00
2.00	City: ALEDO	State: IL	Zip Code: 61231-	County: MERCER	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	GENESIS MEDICAL CENTER - ALEDO	141304	19340	1	05/01/2000	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GENESIS MEDICAL CENTER - ALEDO SWB	14Z304	19340		05/01/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	GENESIS MEDICAL CENTER - ALEDO RHC	143453	19340		02/29/2000	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2022	06/30/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, 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 a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2023 8:47 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	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	45.00
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	46.00
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	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, 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. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1304	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/28/2023 8:47 am

		V	XVIII	XIX	
		1.00	2.00	3.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2023 8:47 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2023 8:47 am

		1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)		
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?	N	68.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		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

		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
		1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		0	88.00

		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		0	89.00

		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

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		V	XIX	
		1.00	2.00	
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
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.	N	Y	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			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.	2			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2023 8:47 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	29,355	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified 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 program, 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 program, 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 program, 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 program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, 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 program, 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 program, 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 a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	H55790	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: GENESIS HEALTH SYSTEM	Contractor's Name: WISCONSIN PHYSICIAN SERVICE HEALTH	Contractor's Number: 05001	141.00
142.00	Street: 1227 E RUSHOLME STREET	PO Box:		142.00
143.00	City: DAVENPORT	State: IA	Zip Code: 52803	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2023 8:47 am

					1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	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
					1.00	
	Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

			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
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/28/2023 8:47 am

		Y/N	Date	
		1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			
	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)	Y			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.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts 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)	Y	08/04/2023	Y	08/04/2023	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)	N		N		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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/28/2023 8:47 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			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.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	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	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVEN.WELLEN@CLACONNECT.COM	43.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2023 8:47 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	8,030	6,888.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		22	8,030	6,888.00	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)		22	8,030	6,888.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		22				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
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2023 8:47 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
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)	121	9	287			1.00
2.00	HMO and other (see instructions)	116	10				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	280	0	700			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	401	9	987			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)	401	9	987	0.00	73.51	14.00
15.00	CAH visits	5,201	4,354	22,365			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,926	6,176	22,346	0.00	20.30	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	93.81	27.00
28.00	Observation Bed Days		7	379			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
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2023 8:47 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
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	35	4	92	1.00
2.00	HMO and other (see instructions)			30	3		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	35	4	92	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	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
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1304 | Component CCN: 14-3453 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 11/28/2023 8:47 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1007 NW 3RD STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ALEDO		IL	61231	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	18:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN	
				1.00		2.00	
14.00	RHC/FQHC name, CCN						14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		MERCER				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1304 | Component CCN: 14-3453 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 11/28/2023 8:47 am

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	07:00	18:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-10 | Date/Time Prepared: 11/28/2023 8:47 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.532508	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,688,586	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	5,146,044	6.00
7.00	Medicaid cost (line 1 times line 6)	2,740,310	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,051,724	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,051,724	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)	332,359	0	332,359	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	176,984	0	176,984	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)	176,984	0	176,984	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)	588,885	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	87,848	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	135,151	27.01
28.00	Non-Medicare bad debt expense (see instructions)	453,734	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	288,920	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	465,904	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,517,628	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/28/2023 8:47 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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		587,570	587,570	36,520	624,090	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		244,729	244,729	14,343	259,072	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,215	786,169	793,384	0	793,384	4.00
5.01	00570	ADMITTING	297,066	14,217	311,283	0	311,283	5.01
5.02	00590	HOSPITAL ONLY A & G	0	406	406	0	406	5.02
5.03	00591	SHARED ADMN & GENERAL	75,247	3,674,697	3,749,944	177,327	3,927,271	5.03
6.00	00600	MAINTENANCE & REPAIRS	25,674	575,228	600,902	-114	600,788	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	43,102	43,102	8.00
9.00	00900	HOUSEKEEPING	0	226,686	226,686	-12,132	214,554	9.00
10.00	01000	DIETARY	0	464	464	0	464	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	21,258	-7,438	13,820	203	14,023	14.00
15.00	01500	PHARMACY	281,236	927,371	1,208,607	-555,459	653,148	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	63,264	5,020	68,284	0	68,284	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	238,873	238,873	-78,065	160,808	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,208,493	230,583	1,439,076	-37,423	1,401,653	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	195,860	127,616	323,476	-33,687	289,789	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	500,437	445,032	945,469	-5,151	940,318	54.00
60.00	06000	LABORATORY	624,242	842,074	1,466,316	-71,949	1,394,367	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	71,949	71,949	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	250,124	73,832	323,956	-20,828	303,128	65.00
66.00	06600	PHYSICAL THERAPY	324,532	133,750	458,282	-93,512	364,770	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	85,405	85,405	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	6,663	6,663	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	68,982	68,982	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,288	10,288	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	565,735	565,735	73.00
76.00	03950	SLEEP LAB	22,544	5,616	28,160	-155	28,005	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,955,132	403,448	2,358,580	-228,361	2,130,219	88.00
91.00	09100	EMERGENCY	889,372	2,402,910	3,292,282	-21,746	3,270,536	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		130,144	130,144	0	130,144	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,741,696	12,068,997	18,810,693	-78,065	18,732,628	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	326,626	142,322	468,948	78,065	547,013	192.00
194.00	07950	KIDNEY CENTER	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	7,068,322	12,211,319	19,279,641	0	19,279,641	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/28/2023 8:47 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	293,734	917,824		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	88,909	347,981		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-108,982	684,402		4.00
5.01	00570	ADMITTING	0	311,283		5.01
5.02	00590	HOSPITAL ONLY A & G	255,882	256,288		5.02
5.03	00591	SHARED ADMN & GENERAL	-881,016	3,046,255		5.03
6.00	00600	MAINTENANCE & REPAIRS	0	600,788		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	52,344	95,446		8.00
9.00	00900	HOUSEKEEPING	0	214,554		9.00
10.00	01000	DIETARY	0	464		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	1,013	1,013		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,744	28,767		14.00
15.00	01500	PHARMACY	-301,498	351,650		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	268,719	268,719		16.00
17.00	01700	SOCIAL SERVICE	14,428	82,712		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	160,808		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-139,499	1,262,154		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	289,789		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-670	939,648		54.00
60.00	06000	LABORATORY	0	1,394,367		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	71,949		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	-22,251	280,877		65.00
66.00	06600	PHYSICAL THERAPY	-987	363,783		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	85,405		67.00
68.00	06800	SPEECH PATHOLOGY	0	6,663		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	68,982		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,288		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-394	565,341		73.00
76.00	03950	SLEEP LAB	0	28,005		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-6,483	2,123,736		88.00
91.00	09100	EMERGENCY	-267,982	3,002,554		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-130,144	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-870,133	17,862,495		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	547,013		192.00
194.00	07950	KIDNEY CENTER	0	0		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-870,133	18,409,508		200.00

RECLASSIFICATIONS | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/28/2023 8:47 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RHC SALARY					
1.00	SHARED ADMN & GENERAL	5.03	213,242	14,948		1.00
	TOTALS		213,242	14,948		
	B - BLOOD					
1.00	BLOOD STORING PROCESSING & TRANS.	63.00	10,961	60,988		1.00
	TOTALS		10,961	60,988		
	C - COST OF IMPLANTS & MEDICAL SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	10,288		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	79,270		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	203		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
	TOTALS		0	89,761		
	E - CRNA					
1.00	PHYSICIANS PRIVATE OFFICES	192.00	0	78,065		1.00
	TOTALS		0	78,065		
	F - THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	2,051	83,354		1.00
2.00	SPEECH PATHOLOGY	68.00	6,051	612		2.00
	TOTALS		8,102	83,966		
	G - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	50,863		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	50,863		
	H - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	565,735		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	565,735		
	J - LAUNDRY COSTS					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	43,102		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
	TOTALS		0	43,102		
500.00	Grand Total: Increases		232,305	987,428		500.00

RECLASSIFICATIONS | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/28/2023 8:47 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RHC SALARY						
1.00	RURAL HEALTH CLINIC	88.00	213,242	14,948	0		1.00
	TOTALS		213,242	14,948			
	B - BLOOD						
1.00	LABORATORY	60.00	10,961	60,988	0		1.00
	TOTALS		10,961	60,988			
	C - COST OF IMPLANTS & MEDICAL SUPPLIES						
1.00	MAINTENANCE & REPAIRS	6.00	0	114	0		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	10,288	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	20,307	0		3.00
4.00	OPERATING ROOM	50.00	0	30,686	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	20,718	0		5.00
6.00	SLEEP LAB	76.00	0	23	0		6.00
7.00	EMERGENCY	91.00	0	7,411	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	214	0		8.00
	TOTALS		0	89,761			
	E - CRNA						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	78,065	0		1.00
	TOTALS		0	78,065			
	F - THERAPY						
1.00	PHYSICAL THERAPY	66.00	8,102	83,966	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		8,102	83,966			
	G - PROPERTY INSURANCE						
1.00	SHARED ADMN & GENERAL	5.03	0	50,863	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	50,863			
	H - DRUGS						
1.00	PHARMACY	15.00	0	555,459	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	4,573	0		2.00
3.00	OPERATING ROOM	50.00	0	69	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,219	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	110	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	520	0		6.00
7.00	EMERGENCY	91.00	0	3,785	0		7.00
	TOTALS		0	565,735			
	J - LAUNDRY COSTS						
1.00	HOUSEKEEPING	9.00	0	12,132	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	12,543	0		2.00
3.00	OPERATING ROOM	50.00	0	2,932	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,718	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	924	0		5.00
6.00	SLEEP LAB	76.00	0	132	0		6.00
7.00	RURAL HEALTH CLINIC	88.00	0	171	0		7.00
8.00	EMERGENCY	91.00	0	10,550	0		8.00
	TOTALS		0	43,102			
500.00	Grand Total: Decreases		232,305	987,428			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 11/28/2023 8:47 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	65,000	263,500	0	263,500	0	1.00
2.00	Land Improvements	327,968	6,732	0	6,732	132,746	2.00
3.00	Buildings and Fixtures	13,490,720	37,842	0	37,842	12,199,916	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	3,894,285	0	0	0	3,208,118	5.00
6.00	Movable Equipment	109,793	45,318	0	45,318	111,146	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	17,887,766	353,392	0	353,392	15,651,926	8.00
9.00	Reconciling Items	-670,746	444,949	0	444,949	0	9.00
10.00	Total (line 8 minus line 9)	18,558,512	-91,557	0	-91,557	15,651,926	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	328,500	0	1.00
2.00	Land Improvements	201,954	0	2.00
3.00	Buildings and Fixtures	1,328,646	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	686,167	0	5.00
6.00	Movable Equipment	43,965	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	2,589,232	0	8.00
9.00	Reconciling Items	-225,797	0	9.00
10.00	Total (line 8 minus line 9)	2,815,029	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 11/28/2023 8:47 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	586,645	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	244,729	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	831,374	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	925	587,570		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	244,729		2.00
3.00	Total (sum of lines 1-2)	925	832,299		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 11/28/2023 8:47 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,859,100	0	1,859,100	0.718012	36,520	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	730,132	0	730,132	0.281988	14,343	2.00
3.00	Total (sum of lines 1-2)	2,589,232	0	2,589,232	1.000000	50,863	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	36,520	880,379	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	14,343	333,638	0	2.00
3.00	Total (sum of lines 1-2)	0	0	50,863	1,214,017	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	36,520	0	925	917,824	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	14,343	0	0	347,981	2.00
3.00	Total (sum of lines 1-2)	0	50,863	0	925	1,265,805	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/28/2023 8:47 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-162	SHARED ADMN & GENERAL	5.03	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-429,732			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	365,841			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-394	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** 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
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	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		0		0.00	0	32.00
33.00	MISC INCOME - A&G	B	-76,350	SHARED ADMN & GENERAL	5.03	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/28/2023 8:47 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC INCOME - RHC	B	-4,925	RURAL HEALTH CLINIC	88.00	0	33.01
34.00	PATIENT PHONES - DEPRECIATION	A	-6	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.00
34.01	PATIENT PHONES - SALARY	A	-888	RURAL HEALTH CLINIC	88.00	0	34.01
34.02	PATIENT PHONES - BENEFITS	A	-100	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.02
34.03	PATIENT PHONES - COSTS	A	-82	SHARED ADMN & GENERAL	5.03	0	34.03
35.00	ADVERTISING	A	-39,158	SHARED ADMN & GENERAL	5.03	0	35.00
35.01	ADVERTISING	A	-670	RADIOLOGY-DIAGNOSTIC	54.00	0	35.01
35.02	ADVERTISING	A	-987	PHYSICAL THERAPY	66.00	0	35.02
35.03	ADVERTISING	A	-670	RURAL HEALTH CLINIC	88.00	0	35.03
36.00	PROVIDER TAX ASSESSMENT	A	-479,771	SHARED ADMN & GENERAL	5.03	0	36.00
36.01	PHYSICIAN PRACTICE OVERHEAD	A	-168,099	SHARED ADMN & GENERAL	5.03	0	36.01
37.00	LOBBYING PORTION OF DUES	A	-6,249	SHARED ADMN & GENERAL	5.03	0	37.00
38.00	EMPLOYEE HEALTH INSURANCE	A	-97,890	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	340B RETAIL PHARMACY	A	-301,498	PHARMACY	15.00	0	39.00
40.00	PHYSICIAN BENEFIT OFFSET	A	-10,992	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00	MEDICARE DEPRECIATION - BLDG	A	293,734	CAP REL COSTS-BLDG & FIXT	1.00	9	41.00
41.01	MEDICARE DEPRECIATION - MME	A	88,915	CAP REL COSTS-MVBLE EQUIP	2.00	9	41.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-870,133				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 11/28/2023 8:47 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.03	SHARED ADMN & GENERAL	HOME OFFICE - ADMIN	74,499	0	1.00
2.00	5.03	SHARED ADMN & GENERAL	HOME OFFICE - DATA PROCESSIN	251,135	1,072,840	2.00
3.00	5.02	HOSPITAL ONLY A & G	HOME OFFICE - SBS PATIENT AC	255,882	0	3.00
4.00	5.03	SHARED ADMN & GENERAL	HOME OFFICE - SBS PATIENT RE	285,053	252,998	4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE - MEDICAL RECORD	268,719	0	4.01
4.02	14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE - CENTRAL SUPPLY	14,744	0	4.02
4.03	5.03	SHARED ADMN & GENERAL	HOME OFFICE - MEDICAL AFFAIR	16,960	0	4.03
4.04	17.00	SOCIAL SERVICE	HOME OFFICE - PASTORAL CARE	14,428	0	4.04
4.05	5.03	SHARED ADMN & GENERAL	HOME OFFICE - PAYOR CONTRACT	4,718	0	4.05
4.06	13.00	NURSING ADMINISTRATION	HOME OFFICE - CARE COORDINAT	1,013	0	4.06
4.07	5.03	SHARED ADMN & GENERAL	HOME OFFICE - PHYSICIAN RECR	9,045	0	4.07
4.08	5.03	SHARED ADMN & GENERAL	HOME OFFICE - LIBRARY	4,862	0	4.08
4.09	5.03	SHARED ADMN & GENERAL	HOME OFFICE - COVID-19	1,302	0	4.09
4.10	5.03	SHARED ADMN & GENERAL	HOME OFFICE - AFFILIATE FACI	276,996	0	4.10
4.11	5.03	SHARED ADMN & GENERAL	HOME OFFICE POOLED - CAPITAL	237,028	0	4.11
4.12	5.03	SHARED ADMN & GENERAL	HOME OFFICE POOLED - NON-CAP	1,276,674	1,223,579	4.12
4.13	8.00	LAUNDRY & LINEN SERVICE	CRESCENT LAUNDRY	80,291	27,947	4.13
4.14	6.00	MAINTENANCE & REPAIRS	VARIOUS SERVICES - RELATED	320	320	4.14
4.15	15.00	PHARMACY	VARIOUS SERVICES - RELATED	242,133	242,133	4.15
4.16	30.00	ADULTS & PEDIATRICS	VARIOUS SERVICES - RELATED	460	460	4.16
4.17	50.00	OPERATING ROOM	VARIOUS SERVICES - RELATED	1,325	1,325	4.17
4.18	60.00	LABORATORY	VARIOUS SERVICES - RELATED	150,825	150,825	4.18
4.19	65.00	RESPIRATORY THERAPY	VARIOUS SERVICES - RELATED	5	5	4.19
4.20	66.00	PHYSICAL THERAPY	VARIOUS SERVICES - RELATED	125	125	4.20
4.21	88.00	RURAL HEALTH CLINIC	VARIOUS SERVICES - RELATED	410	410	4.21
4.22	91.00	EMERGENCY	VARIOUS SERVICES - RELATED	1,450	1,450	4.22
4.23	192.00	PHYSICIANS PRIVATE OFFICES	VARIOUS SERVICES - RELATED	1,315	1,315	4.23
4.24	113.00	INTEREST EXPENSE	INTEREST EXPENSE - RELATED	0	130,144	4.24
4.25	88.00	RURAL HEALTH CLINIC	GHG - MGMT FEE	121,242	121,242	4.25
4.26	192.00	PHYSICIANS PRIVATE OFFICES	GHG - MGMT FEE	22,806	22,806	4.26
4.27	5.03	SHARED ADMN & GENERAL	VARIOUS SERVICES - RELATED	4,675	4,675	4.27
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,620,440	3,254,599	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B	GMC ALEDO	100.00	GENESIS HLTH SY	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-1304	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-1 Date/Time Prepared: 11/28/2023 8:47 am

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 11/28/2023 8:47 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	74,499	0		1.00
2.00	-821,705	0		2.00
3.00	255,882	0		3.00
4.00	32,055	0		4.00
4.01	268,719	0		4.01
4.02	14,744	0		4.02
4.03	16,960	0		4.03
4.04	14,428	0		4.04
4.05	4,718	0		4.05
4.06	1,013	0		4.06
4.07	9,045	0		4.07
4.08	4,862	0		4.08
4.09	1,302	0		4.09
4.10	276,996	0		4.10
4.11	237,028	0		4.11
4.12	53,095	0		4.12
4.13	52,344	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
4.23	0	0		4.23
4.24	-130,144	0		4.24
4.25	0	0		4.25
4.26	0	0		4.26
4.27	0	0		4.27
5.00	365,841			5.00

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

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

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

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

6.00	NOT-FOR PROFIT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 11/28/2023 8:47 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	139,499	139,499	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	22,251	22,251	0	0	0	2.00
3.00	91.00	EMERGENCY	2,050,090	267,982	1,782,108	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,211,840	429,732	1,782,108		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	139,499		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	22,251		2.00
3.00	91.00	EMERGENCY	0	0	0	267,982		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	429,732		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1304	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/28/2023 8:47 am

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		212	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		6.40	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	1,481.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	87.40	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)	43.70	43.70	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)	129,439	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	129,439	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)	129,439	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)	129,439	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)	9,264	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)	9,264	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)	1,357	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	10,621	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)	10,621	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1304	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/28/2023 8:47 am

		Occupational 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)	87.40	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)		129,439	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		10,621	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)		140,060	63.00
64.00	Total cost of outside supplier services (from your records)		76,689	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		9,264	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,357	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		10,621	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		1,357	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		1,357	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: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/28/2023 8:47 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	917,824	917,824				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	347,981		347,981			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	684,402	0	0	684,402		4.00
5.01	00570	ADMITTING	311,283	0	0	29,459	340,742	5.01
5.02	00590	HOSPITAL ONLY A & G	256,288	0	0	0	0	5.02
5.03	00591	SHARED ADMN & GENERAL	3,046,255	180,636	16,838	28,609	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	600,788	52,728	24,938	2,546	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	95,446	2,463	0	0	0	8.00
9.00	00900	HOUSEKEEPING	214,554	10,572	0	0	0	9.00
10.00	01000	DIETARY	464	37,666	2,078	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,013	1,914	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,767	31,735	5,040	2,108	0	14.00
15.00	01500	PHARMACY	351,650	11,216	13,328	25,977	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	268,719	4,130	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	82,712	4,604	0	6,274	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	160,808	1,061	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,262,154	211,672	28,540	106,010	30,044	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	289,789	95,907	55,388	19,423	17,268	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	939,648	83,478	138,469	49,627	103,615	54.00
60.00	06000	LABORATORY	1,394,367	32,095	3,889	60,818	74,215	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	71,949	0	0	1,087	1,326	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	280,877	6,025	8,165	24,804	8,948	65.00
66.00	06600	PHYSICAL THERAPY	363,783	32,531	1,884	31,380	16,415	66.00
67.00	06700	OCCUPATIONAL THERAPY	85,405	12,258	608	203	2,705	67.00
68.00	06800	SPEECH PATHOLOGY	6,663	208	13	600	218	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	68,982	0	0	0	4,875	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,288	0	0	0	446	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	565,341	0	0	0	33,732	73.00
76.00	03950	SLEEP LAB	28,005	20,576	2,655	2,236	2,600	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,123,736	0	0	172,653	0	88.00
91.00	09100	EMERGENCY	3,002,554	44,941	44,540	88,197	44,335	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,862,495	878,416	346,373	652,011	340,742	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	4,869	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	547,013	34,539	1,608	32,391	0	192.00
194.00	07950	KIDNEY CENTER	0	0	0	0	0	194.00
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)	18,409,508	917,824	347,981	684,402	340,742	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/28/2023 8:47 am

		Cost Center Description	Subtotal	HOSPITAL ONLY A & G	Subtotal	SHARED ADMN & GENERAL	MAINTENANCE & REPAIRS	
			5A.01	5.02	5A.02	5.03	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G	256,288	256,288				5.02
5.03	00591	SHARED ADMN & GENERAL	3,272,338	55,040	3,327,378	3,327,378		5.03
6.00	00600	MAINTENANCE & REPAIRS	681,000	11,455	692,455	152,767	845,222	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	97,909	1,647	99,556	21,964	3,042	8.00
9.00	00900	HOUSEKEEPING	225,126	3,787	228,913	50,502	13,055	9.00
10.00	01000	DIETARY	40,208	676	40,884	9,020	46,512	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,927	49	2,976	657	2,363	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	67,650	1,138	68,788	15,176	39,189	14.00
15.00	01500	PHARMACY	402,171	6,765	408,936	90,218	13,851	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	272,849	4,590	277,439	61,208	5,100	16.00
17.00	01700	SOCIAL SERVICE	93,590	1,574	95,164	20,995	5,685	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	161,869	2,723	164,592	36,312	1,310	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,638,420	27,560	1,665,980	367,544	261,385	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	477,775	8,037	485,812	107,178	118,433	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,314,837	22,117	1,336,954	294,955	103,085	54.00
60.00	06000	LABORATORY	1,565,384	26,331	1,591,715	351,159	39,634	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	74,362	1,251	75,613	16,682	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	328,819	5,531	334,350	73,763	7,440	65.00
66.00	06600	PHYSICAL THERAPY	445,993	7,502	453,495	100,049	40,172	66.00
67.00	06700	OCCUPATIONAL THERAPY	101,179	1,702	102,881	22,697	15,138	67.00
68.00	06800	SPEECH PATHOLOGY	7,702	130	7,832	1,728	257	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	73,857	1,242	75,099	16,568	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,734	181	10,915	2,408	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	599,073	10,077	609,150	134,389	0	73.00
76.00	03950	SLEEP LAB	56,072	943	57,015	12,578	25,409	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,296,389	0	2,296,389	506,622	0	88.00
91.00	09100	EMERGENCY	3,224,567	54,240	3,278,807	723,364	55,497	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0			92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,789,088	256,288	17,789,088	3,190,503	796,557	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	4,869	0	4,869	1,074	6,013	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	615,551	0	615,551	135,801	42,652	192.00
194.00	07950	KIDNEY CENTER	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments	0		0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,409,508	256,288	18,409,508	3,327,378	845,222	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/28/2023 8:47 am

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	124,562					8.00
9.00	00900	HOUSEKEEPING	0	292,470				9.00
10.00	01000	DIETARY	0	16,407	112,823			10.00
11.00	01100	CAFETERIA	0	0	5,871	5,871		11.00
13.00	01300	NURSING ADMINISTRATION	0	834	0	0	6,830	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	13,824	0	30	0	14.00
15.00	01500	PHARMACY	0	4,886	0	172	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,799	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,005	0	54	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	462	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,254	92,202	106,952	1,113	3,796	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,715	41,777	0	184	615	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,358	36,363	0	472	0	54.00
60.00	06000	LABORATORY	0	13,981	0	747	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	12	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,624	0	217	0	65.00
66.00	06600	PHYSICAL THERAPY	2,454	14,170	0	187	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	792	5,340	0	43	0	67.00
68.00	06800	SPEECH PATHOLOGY	17	91	0	68	0	68.00
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	SLEEP LAB	0	8,963	0	23	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	766	0	0	1,368	0	88.00
91.00	09100	EMERGENCY	43,206	19,576	0	785	2,419	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	124,562	275,304	112,823	5,475	6,830	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	2,121	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	15,045	0	396	0	192.00
194.00	07950	KIDNEY CENTER	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	124,562	292,470	112,823	5,871	6,830	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/28/2023 8:47 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			14.00	15.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
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	137,007					14.00
15.00	01500	PHARMACY	928	518,991				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	345,546			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	123,903		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	202,676	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,953	0	30,468	123,903	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,155	0	17,512	0	202,676	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,796	0	105,070	0	0	54.00
60.00	06000	LABORATORY	18,109	0	75,263	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	1,345	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,205	0	9,075	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,259	0	16,647	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,053	0	2,743	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	21	0	221	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	31,446	0	4,944	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,683	0	452	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	518,991	34,208	0	0	73.00
76.00	03950	SLEEP LAB	1,735	0	2,637	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,116	0	0	0	0	88.00
91.00	09100	EMERGENCY	18,194	0	44,961	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	133,653	518,991	345,546	123,903	202,676	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	3,354	0	0	0	0	192.00
194.00	07950	KIDNEY CENTER	0	0	0	0	0	194.00
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)	137,007	518,991	345,546	123,903	202,676	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/28/2023 8:47 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00590	HOSPITAL ONLY A & G					5.02
5.03	00591	SHARED ADMN & GENERAL					5.03
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	2,719,550	-401,444	2,318,106		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	996,057	0	996,057		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,911,053	0	1,911,053		54.00
60.00	06000	LABORATORY	2,090,608	0	2,090,608		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	93,652	0	93,652		63.00
64.00	06400	INTRAVENOUS THERAPY	0	396,213	396,213		64.00
65.00	06500	RESPIRATORY THERAPY	428,674	0	428,674		65.00
66.00	06600	PHYSICAL THERAPY	630,433	0	630,433		66.00
67.00	06700	OCCUPATIONAL THERAPY	150,687	0	150,687		67.00
68.00	06800	SPEECH PATHOLOGY	10,235	0	10,235		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	128,057	0	128,057		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,458	0	18,458		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,296,738	0	1,296,738		73.00
76.00	03950	SLEEP LAB	108,360	0	108,360		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,813,261	0	2,813,261		88.00
91.00	09100	EMERGENCY	4,186,809	5,231	4,192,040		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,582,632	0	17,582,632		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	14,077	0	14,077		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	812,799	0	812,799		192.00
194.00	07950	KIDNEY CENTER	0	0	0		194.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	18,409,508	0	18,409,508		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/28/2023 8:47 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00570	ADMITTING	0	0	0	0	0	5.01
5.02	00590	HOSPITAL ONLY A & G	0	0	0	0	0	5.02
5.03	00591	SHARED ADMN & GENERAL	265,796	180,636	16,838	463,270	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	52,728	24,938	77,666	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,320	2,463	0	7,783	0	8.00
9.00	00900	HOUSEKEEPING	0	10,572	0	10,572	0	9.00
10.00	01000	DIETARY	0	37,666	2,078	39,744	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,914	0	1,914	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	31,735	5,040	36,775	0	14.00
15.00	01500	PHARMACY	0	11,216	13,328	24,544	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,130	0	4,130	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,604	0	4,604	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	1,061	0	1,061	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29	211,672	28,540	240,241	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	95,907	55,388	151,295	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	83,478	138,469	221,947	0	54.00
60.00	06000	LABORATORY	0	32,095	3,889	35,984	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,707	6,025	8,165	16,897	0	65.00
66.00	06600	PHYSICAL THERAPY	0	32,531	1,884	34,415	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,258	608	12,866	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	208	13	221	0	68.00
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	SLEEP LAB	0	20,576	2,655	23,231	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	67,629	0	0	67,629	0	88.00
91.00	09100	EMERGENCY	0	44,941	44,540	89,481	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	341,481	878,416	346,373	1,566,270	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	4,869	0	4,869	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	25,343	34,539	1,608	61,490	0	192.00
194.00	07950	KIDNEY CENTER	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	366,824	917,824	347,981	1,632,629	0	202.00

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		Cost Center Description	ADMITTING	HOSPITAL ONLY A & G	SHARED ADMN & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	6.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	0					5.01
5.02	00590	HOSPITAL ONLY A & G	0	0				5.02
5.03	00591	SHARED ADMN & GENERAL	0	0	463,270			5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	21,269	98,935		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	3,058	356	11,197	8.00
9.00	00900	HOUSEKEEPING	0	0	7,031	1,528	0	9.00
10.00	01000	DIETARY	0	0	1,256	5,444	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	91	277	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,113	4,587	0	14.00
15.00	01500	PHARMACY	0	0	12,561	1,621	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	8,522	597	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	2,923	665	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	5,056	153	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	51,172	30,598	4,606	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	14,922	13,863	1,053	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	41,066	12,066	1,291	54.00
60.00	06000	LABORATORY	0	0	48,891	4,639	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	2,323	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	10,270	871	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	13,930	4,702	221	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	3,160	1,772	71	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	241	30	2	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,307	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	335	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	18,711	0	0	73.00
76.00	03950	SLEEP LAB	0	0	1,751	2,974	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	70,536	0	69	88.00
91.00	09100	EMERGENCY	0	0	100,718	6,496	3,884	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	444,213	93,239	11,197	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	150	704	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	18,907	4,992	0	192.00
194.00	07950	KIDNEY CENTER	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	463,270	98,935	11,197	202.00

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		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	19,131					9.00
10.00	01000	DIETARY	1,073	47,517				10.00
11.00	01100	CAFETERIA	0	2,473	2,473			11.00
13.00	01300	NURSING ADMINISTRATION	55	0	0	2,337		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	904	0	13	0	44,392	14.00
15.00	01500	PHARMACY	320	0	72	0	301	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	118	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	131	0	23	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	30	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,030	45,044	469	1,298	4,845	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,733	0	77	211	3,290	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,379	0	199	0	6,414	54.00
60.00	06000	LABORATORY	914	0	315	0	5,868	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	5	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	172	0	92	0	391	65.00
66.00	06600	PHYSICAL THERAPY	927	0	79	0	1,056	66.00
67.00	06700	OCCUPATIONAL THERAPY	349	0	18	0	341	67.00
68.00	06800	SPEECH PATHOLOGY	6	0	29	0	7	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	10,187	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,518	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SLEEP LAB	586	0	10	0	562	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	574	0	2,630	88.00
91.00	09100	EMERGENCY	1,281	0	331	828	5,895	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,008	47,517	2,306	2,337	43,305	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	139	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	984	0	167	0	1,087	192.00
194.00	07950	KIDNEY CENTER	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,131	47,517	2,473	2,337	44,392	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/28/2023 8:47 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
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	39,419					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,367				16.00
17.00	01700	SOCIAL SERVICE	0	0	8,346			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	6,300		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,179	8,346		393,828	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	678	0		188,122	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,062	0		289,424	54.00
60.00	06000	LABORATORY	0	2,912	0		99,523	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	52	0		2,380	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		0	64.00
65.00	06500	RESPIRATORY THERAPY	0	351	0		29,044	65.00
66.00	06600	PHYSICAL THERAPY	0	644	0		55,974	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	106	0		18,683	67.00
68.00	06800	SPEECH PATHOLOGY	0	9	0		545	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	191	0		12,685	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	17	0		1,870	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,419	1,324	0		59,454	73.00
76.00	03950	SLEEP LAB	0	102	0		29,216	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0		141,438	88.00
91.00	09100	EMERGENCY	0	1,740	0		210,654	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,419	13,367	8,346	0	1,532,840	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0		5,862	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0		87,627	192.00
194.00	07950	KIDNEY CENTER	0	0	0		0	194.00
200.00		Cross Foot Adjustments				6,300	6,300	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	39,419	13,367	8,346	6,300	1,632,629	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/28/2023 8:47 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00590	HOSPITAL ONLY A & G				5.02
5.03	00591	SHARED ADMN & GENERAL				5.03
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	0	393,828		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	188,122		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	289,424		54.00
60.00	06000	LABORATORY	0	99,523		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	2,380		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	29,044		65.00
66.00	06600	PHYSICAL THERAPY	0	55,974		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,683		67.00
68.00	06800	SPEECH PATHOLOGY	0	545		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	12,685		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,870		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	59,454		73.00
76.00	03950	SLEEP LAB	0	29,216		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	141,438		88.00
91.00	09100	EMERGENCY	0	210,654		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,532,840		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	5,862		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	87,627		192.00
194.00	07950	KIDNEY CENTER	0	0		194.00
200.00		Cross Foot Adjustments	0	6,300		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,632,629		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/28/2023 8:47 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	
			1.00	2.00	4.00	5.01	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	48,443					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		333,638				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	6,901,432			4.00
5.01	00570	ADMITTING	0	0	297,066	28,631,560		5.01
5.02	00590	HOSPITAL ONLY A & G	0	0	0	0	-256,288	5.02
5.03	00591	SHARED ADMN & GENERAL	9,534	16,144	288,489	0	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	2,783	23,910	25,674	0	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	130	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	558	0	0	0	0	9.00
10.00	01000	DIETARY	1,988	1,992	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	101	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,675	4,832	21,258	0	0	14.00
15.00	01500	PHARMACY	592	12,779	261,948	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	218	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	243	0	63,264	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	56	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,172	27,364	1,068,994	2,524,479	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,062	53,105	195,860	1,450,950	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,406	132,762	500,437	8,706,446	0	54.00
60.00	06000	LABORATORY	1,694	3,729	613,281	6,236,070	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	10,961	111,455	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	318	7,828	250,124	751,889	0	65.00
66.00	06600	PHYSICAL THERAPY	1,717	1,806	316,430	1,379,329	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	647	583	2,051	227,296	0	67.00
68.00	06800	SPEECH PATHOLOGY	11	12	6,051	18,351	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	409,641	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	37,447	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,834,380	0	73.00
76.00	03950	SLEEP LAB	1,086	2,546	22,544	218,469	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,741,002	0	-2,296,389	88.00
91.00	09100	EMERGENCY	2,372	42,704	889,372	3,725,358	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,363	332,096	6,574,806	28,631,560	-2,552,677	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	257	0	0	0	-4,869	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,823	1,542	326,626	0	-615,551	192.00
194.00	07950	KIDNEY CENTER	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	917,824	347,981	684,402	340,742		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.946473	1.042990	0.099168	0.011901		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	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: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/28/2023 8:47 am

		Cost Center Description	HOSPITAL ONLY A & G (ACCUM. COST)	Reconciliation	SHARED ADMN & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5.02	5A.03	5.03	6.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G	15,236,411					5.02
5.03	00591	SHARED ADMN & GENERAL	3,272,338	-3,327,378	15,082,130			5.03
6.00	00600	MAINTENANCE & REPAIRS	681,000	0	692,455	36,126		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	97,909	0	99,556	130	42,795	8.00
9.00	00900	HOUSEKEEPING	225,126	0	228,913	558	0	9.00
10.00	01000	DIETARY	40,208	0	40,884	1,988	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,927	0	2,976	101	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	67,650	0	68,788	1,675	0	14.00
15.00	01500	PHARMACY	402,171	0	408,936	592	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	272,849	0	277,439	218	0	16.00
17.00	01700	SOCIAL SERVICE	93,590	0	95,164	243	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	161,869	0	164,592	56	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,638,420	0	1,665,980	11,172	17,609	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	477,775	0	485,812	5,062	4,025	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,314,837	0	1,336,954	4,406	4,933	54.00
60.00	06000	LABORATORY	1,565,384	0	1,591,715	1,694	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	74,362	0	75,613	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	328,819	0	334,350	318	0	65.00
66.00	06600	PHYSICAL THERAPY	445,993	0	453,495	1,717	843	66.00
67.00	06700	OCCUPATIONAL THERAPY	101,179	0	102,881	647	272	67.00
68.00	06800	SPEECH PATHOLOGY	7,702	0	7,832	11	6	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	73,857	0	75,099	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,734	0	10,915	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	599,073	0	609,150	0	0	73.00
76.00	03950	SLEEP LAB	56,072	0	57,015	1,086	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	2,296,389	0	263	88.00
91.00	09100	EMERGENCY	3,224,567	0	3,278,807	2,372	14,844	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,236,411	-3,327,378	14,461,710	34,046	42,795	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	4,869	257	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	615,551	1,823	0	192.00
194.00	07950	KIDNEY CENTER	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	256,288		3,327,378	845,222	124,562	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.016821		0.220617	23.396501	2.910667	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		463,270	98,935	11,197	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.030716	2.738609	0.261643	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: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/28/2023 8:47 am

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	35,438					9.00
10.00	01000	DIETARY	1,988	4,670				10.00
11.00	01100	CAFETERIA	0	243	8,404			11.00
13.00	01300	NURSING ADMINISTRATION	101	0	0	52,331		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,675	0	43	0	300,957	14.00
15.00	01500	PHARMACY	592	0	246	0	2,038	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	218	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	243	0	77	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	56	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,172	4,427	1,593	29,084	32,847	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,062	0	263	4,715	22,308	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,406	0	676	0	43,486	54.00
60.00	06000	LABORATORY	1,694	0	1,070	0	39,780	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	17	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	318	0	311	0	2,648	65.00
66.00	06600	PHYSICAL THERAPY	1,717	0	267	0	7,159	66.00
67.00	06700	OCCUPATIONAL THERAPY	647	0	62	0	2,313	67.00
68.00	06800	SPEECH PATHOLOGY	11	0	98	0	47	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	69,071	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	10,288	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SLEEP LAB	1,086	0	33	0	3,812	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,957	0	17,828	88.00
91.00	09100	EMERGENCY	2,372	0	1,124	18,532	39,965	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,358	4,670	7,837	52,331	293,590	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	257	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,823	0	567	0	7,367	192.00
194.00	07950	KIDNEY CENTER	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	292,470	112,823	5,871	6,830	137,007	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.253005	24.159101	0.698596	0.130515	0.455238	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	19,131	47,517	2,473	2,337	44,392	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.539844	10.174946	0.294265	0.044658	0.147503	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: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/28/2023 8:47 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)		
			15.00	16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
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	565,735					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,631,560				16.00
17.00	01700	SOCIAL SERVICE	0	0	1,592			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,524,479	1,592	0		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,450,950	0	100		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,706,446	0	0		54.00
60.00	06000	LABORATORY	0	6,236,070	0	0		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	111,455	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	751,889	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	1,379,329	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	227,296	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	18,351	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	409,641	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	37,447	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	565,735	2,834,380	0	0		73.00
76.00	03950	SLEEP LAB	0	218,469	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
91.00	09100	EMERGENCY	0	3,725,358	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	565,735	28,631,560	1,592	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	KIDNEY CENTER	0	0	0	0		194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	518,991	345,546	123,903	202,676		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.917375	0.012069	77.828518	2,026.760000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	39,419	13,367	8,346	6,300		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.069677	0.000467	5.242462	63.000000		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

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-2 | Date/Time Prepared: 11/28/2023 8:47 am

		Description	Worksheet CODE	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		ADULTS & PEDIATRICS	1	30.00	-401,444	7.00
8.00		IV THERAPY	1	64.00	396,213	8.00
9.00		EMERGENCY ROOM	1	91.00	5,231	9.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/28/2023 8:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,318,106		2,318,106	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	996,057		996,057	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,911,053		1,911,053	0	0	54.00
60.00	06000	LABORATORY	2,090,608		2,090,608	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	93,652		93,652	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	396,213		396,213	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	428,674	0	428,674	0	0	65.00
66.00	06600	PHYSICAL THERAPY	630,433	0	630,433	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	150,687	0	150,687	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,235	0	10,235	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	128,057		128,057	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,458		18,458	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,296,738		1,296,738	0	0	73.00
76.00	03950	SLEEP LAB	108,360		108,360	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,813,261		2,813,261	0	0	88.00
91.00	09100	EMERGENCY	4,192,040		4,192,040	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	643,167		643,167		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,225,799	0	18,225,799	0	0	200.00
201.00		Less Observation Beds	643,167		643,167		0	201.00
202.00		Total (see instructions)	17,582,632	0	17,582,632	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/28/2023 8:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	959,781		959,781			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,450,950	1,450,950	0.686486	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109,188	8,597,258	8,706,446	0.219499	0.000000	54.00
60.00	06000	LABORATORY	234,606	6,001,464	6,236,070	0.335244	0.000000	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	2,855	108,600	111,455	0.840267	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	145,341	661,300	806,641	0.491189	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	130,444	621,445	751,889	0.570129	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	149,893	1,229,436	1,379,329	0.457058	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	100,979	126,317	227,296	0.662955	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	496	17,855	18,351	0.557735	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	106,142	303,499	409,641	0.312608	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	37,447	37,447	0.492910	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	418,185	2,416,195	2,834,380	0.457503	0.000000	73.00
76.00	03950	SLEEP LAB	0	218,469	218,469	0.495997	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	105,525	4,281,450	4,386,975			88.00
91.00	09100	EMERGENCY	14,031	3,711,327	3,725,358	1.125272	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	13,687	744,370	758,057	0.848441	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	2,491,153	30,527,382	33,018,535			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,491,153	30,527,382	33,018,535			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/28/2023 8:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
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	SLEEP LAB	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 11/28/2023 8:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	188,122	1,450,950	0.129654	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	289,424	8,706,446	0.033242	23,355	776	54.00
60.00	06000	LABORATORY	99,523	6,236,070	0.015959	60,532	966	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	2,380	111,455	0.021354	1,142	24	63.00
64.00	06400	INTRAVENOUS THERAPY	0	806,641	0.000000	25,556	0	64.00
65.00	06500	RESPIRATORY THERAPY	29,044	751,889	0.038628	38,707	1,495	65.00
66.00	06600	PHYSICAL THERAPY	55,974	1,379,329	0.040581	7,546	306	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,683	227,296	0.082197	8,679	713	67.00
68.00	06800	SPEECH PATHOLOGY	545	18,351	0.029699	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,685	409,641	0.030966	28,455	881	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,870	37,447	0.049937	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,454	2,834,380	0.020976	69,048	1,448	73.00
76.00	03950	SLEEP LAB	29,216	218,469	0.133731	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	141,438	4,386,975	0.032240	0	0	88.00
91.00	09100	EMERGENCY	210,654	3,725,358	0.056546	11,299	639	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	109,269	758,057	0.144144	8,018	1,156	92.00
200.00		Total (lines 50 through 199)	1,248,281	32,058,754		282,337	8,404	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/28/2023 8:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	202,676	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	202,676	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/28/2023 8:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	202,676	0	1,450,950	0.139685	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	8,706,446	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	6,236,070	0.000000	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	111,455	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	806,641	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	751,889	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,379,329	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	227,296	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	18,351	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	409,641	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	37,447	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,834,380	0.000000	73.00
76.00	03950	SLEEP LAB	0	0	0	218,469	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,386,975	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	3,725,358	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	758,057	0.000000	92.00
200.00		Total (lines 50 through 199)	0	202,676	0	32,058,754		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/28/2023 8:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	23,355	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	60,532	0	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.000000	1,142	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	25,556	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	38,707	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	7,546	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	8,679	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	28,455	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	69,048	0	0	0	73.00
76.00	03950	SLEEP LAB	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	11,299	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	8,018	0	0	0	92.00
200.00		Total (lines 50 through 199)		282,337	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/28/2023 8:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.686486	0	306,165	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.219499	0	2,096,576	0	0	54.00
60.00	06000	LABORATORY	0.335244	0	1,260,489	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.840267	0	25,457	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.491189	0	283,708	720	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.570129	0	150,513	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.457058	0	264,181	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.662955	0	23,523	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.557735	0	6,552	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.312608	0	74,417	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.492910	0	10,749	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.457503	0	1,037,287	614	0	73.00
76.00	03950	SLEEP LAB	0.495997	0	47,470	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	1.125272	0	801,587	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.848441	0	214,483	0	0	92.00
200.00		Subtotal (see instructions)		0	6,603,157	1,334	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	6,603,157	1,334	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/28/2023 8:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	210,178	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	460,196	0		54.00
60.00	06000	LABORATORY	422,571	0		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	21,391	0		63.00
64.00	06400	INTRAVENOUS THERAPY	139,354	354		64.00
65.00	06500	RESPIRATORY THERAPY	85,812	0		65.00
66.00	06600	PHYSICAL THERAPY	120,746	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	15,595	0		67.00
68.00	06800	SPEECH PATHOLOGY	3,654	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,263	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,298	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	474,562	281		73.00
76.00	03950	SLEEP LAB	23,545	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	902,003	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	181,976	0		92.00
200.00		Subtotal (see instructions)	3,090,144	635		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,090,144	635		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/28/2023 8:47 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,366	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	666	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)	287	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	263	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)	437	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	121	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)	139	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)	141	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	188.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	208.70	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,318,106	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,187,900	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,130,206	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,130,206	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,697.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	205,337	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)	205,337	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/28/2023 8:47 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	130,205	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	335,542	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
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	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	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 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)	235,883	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	239,277	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	475,160	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)	379	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,697.01	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	643,167	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/28/2023 8:47 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	393,828	2,318,106	0.169892	643,167	109,269	90.00
91.00	Nursing Program cost	0	2,318,106	0.000000	643,167	0	91.00
92.00	Allied health cost	0	2,318,106	0.000000	643,167	0	92.00
93.00	All other Medical Education	0	2,318,106	0.000000	643,167	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/28/2023 8:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		123,475		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.686486	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.219499	23,355	5,126	54.00
60.00	06000	LABORATORY	0.335244	60,532	20,293	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.840267	1,142	960	63.00
64.00	06400	INTRAVENOUS THERAPY	0.491189	25,556	12,553	64.00
65.00	06500	RESPIRATORY THERAPY	0.570129	38,707	22,068	65.00
66.00	06600	PHYSICAL THERAPY	0.457058	7,546	3,449	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.662955	8,679	5,754	67.00
68.00	06800	SPEECH PATHOLOGY	0.557735	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.312608	28,455	8,895	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.492910	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.457503	69,048	31,590	73.00
76.00	03950	SLEEP LAB	0.495997	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	1.125272	11,299	12,714	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.848441	8,018	6,803	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		282,337	130,205	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)		282,337		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1304 | Component CCN: 14-Z304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/28/2023 8:47 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.686486	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.219499	6,610	1,451	54.00
60.00	06000	LABORATORY	0.335244	36,641	12,284	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.840267	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.491189	47,906	23,531	64.00
65.00	06500	RESPIRATORY THERAPY	0.570129	14,921	8,507	65.00
66.00	06600	PHYSICAL THERAPY	0.457058	62,491	28,562	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.662955	39,794	26,382	67.00
68.00	06800	SPEECH PATHOLOGY	0.557735	364	203	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.312608	16,662	5,209	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.492910	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.457503	120,196	54,990	73.00
76.00	03950	SLEEP LAB	0.495997	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	1.125272	2,731	3,073	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.848441	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		348,316	164,192	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)		348,316		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1304	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/28/2023 8:47 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,090,779	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH 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)	3,090,779	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)	3,121,687	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)	18,135	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,049,291	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)	2,054,261	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	2,054,261	30.00
31.00	Primary payer payments	2,285	31.00
32.00	Subtotal (line 30 minus line 31)	2,051,976	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)	130,439	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	84,785	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	115,103	36.00
37.00	Subtotal (see instructions)	2,136,761	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
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
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)	2,136,761	40.00
40.01	Sequestration adjustment (see instructions)	42,735	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	2,061,361	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)	32,665	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)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1304	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/28/2023 8:47 am
	Title XVIII	Hospital	Cost

		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2023 8:47 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		341,113		2,061,361	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		341,113		2,061,361	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		32,665	6.01
6.02	SETTLEMENT TO PROGRAM		47,768		0	6.02
7.00	Total Medicare program liability (see instructions)		293,345		2,094,026	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1304 | Component CCN: 14-Z304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2023 8:47 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		652,634		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		652,634		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		20,957		0	6.02
7.00	Total Medicare program liability (see instructions)		631,677		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1304	Period: From 07/01/2022 To 06/30/2023	Worksheet E-1 Part II Date/Time Prepared: 11/28/2023 8:47 am
	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 (see instructions)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (see instructions)		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-1304 | Component CCN: 14-Z304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-2 | Date/Time Prepared: 11/28/2023 8:47 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	479,912	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)	165,834	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	280	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)	645,746	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	645,746	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)	645,746	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,178	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	644,568	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)	644,568	0	19.00
19.01	Sequestration adjustment (see instructions)	12,891	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	652,634	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)	-20,957	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: 14-1304	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part V Date/Time Prepared: 11/28/2023 8:47 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	335,542	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	335,542	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	338,897	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)	338,897	19.00
20.00	Deductibles (exclude professional component)	42,628	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	296,269	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	296,269	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	4,712	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	3,063	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	4,712	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	299,332	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	299,332	30.00
30.01	Sequestration adjustment (see instructions)	5,987	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	341,113	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-47,768	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G | Date/Time Prepared: 11/28/2023 8:47 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	418,188	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,640,883	0	0	0	4.00
5.00	Other receivable	80	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,819,373	0	0	0	6.00
7.00	Inventory	181,793	0	0	0	7.00
8.00	Prepaid expenses	90,050	0	0	0	8.00
9.00	Other current assets	4,155,498	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,667,119	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	328,500	0	0	0	12.00
13.00	Land improvements	201,954	0	0	0	13.00
14.00	Accumulated depreciation	-6,732	0	0	0	14.00
15.00	Buildings	1,328,646	0	0	0	15.00
16.00	Accumulated depreciation	-29,525	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	691,880	0	0	0	19.00
20.00	Accumulated depreciation	-40,681	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	2,474,042	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,390,429	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	282,142	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,672,571	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	10,813,732	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	101,554	0	0	0	37.00
38.00	Salaries, wages, and fees payable	442,579	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,202,009	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	5,434,245	0	0	0	43.00
44.00	Other current liabilities	472,109	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,652,496	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,168,389	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	92,388	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,260,777	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,913,273	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	1,900,459				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	1,900,459	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	10,813,732	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-1 | Date/Time Prepared: 11/28/2023 8:47 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		6,743,799		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,056,249				2.00
3.00	Total (sum of line 1 and line 2)		8,800,048		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		8,800,048		0		11.00
12.00	CHANGE IN PY FUND BALANCE	6,899,589		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		6,899,589		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,900,459		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1304 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/28/2023 8:47 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	467,946		467,946	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	477,080		477,080	5.00
6.00	Swing bed - NF	14,755		14,755	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)	959,781		959,781	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)	959,781		959,781	17.00
18.00	Ancillary services	1,398,129	22,060,526	23,458,655	18.00
19.00	Outpatient services	27,718	4,493,403	4,521,121	19.00
20.00	RURAL HEALTH CLINIC	0	4,386,975	4,386,975	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
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRIVATE OFFICES	0	1,278,874	1,278,874	27.00
27.01	HOSPITAL PROFESSIONAL CHARGES	63,038	1,606,936	1,669,974	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,448,666	33,826,714	36,275,380	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		19,279,641		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		19,279,641		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1304	Period: From 07/01/2022 To 06/30/2023	Worksheet G-3 Date/Time Prepared: 11/28/2023 8:47 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	36,275,380	1.00
2.00	Less contractual allowances and discounts on patients' accounts	17,349,676	2.00
3.00	Net patient revenues (line 1 minus line 2)	18,925,704	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	19,279,641	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-353,937	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	330,785	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	162	10.00
11.00	Rebates and refunds of expenses	102	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	22,263	22.00
23.00	Governmental appropriations	-1,109	23.00
24.00	MISC REVENUE	8,649	24.00
24.01	RETAIL PHARMACY REVENUE (NET)	2,049,334	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	2,410,186	25.00
26.00	Total (line 5 plus line 25)	2,056,249	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,056,249	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1304 | Component CCN: 14-3453 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/28/2023 8:47 am

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	332,889	23,336	356,225	-266	355,959	1.00
2.00	Physician Assistant	122,444	8,583	131,027	0	131,027	2.00
3.00	Nurse Practitioner	498,177	34,923	533,100	-4,835	528,265	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	274,988	19,277	294,265	0	294,265	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	72,890	5,110	78,000	-1,261	76,739	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	214,502	15,037	229,539	0	229,539	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,515,890	106,266	1,622,156	-6,362	1,615,794	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	34,188	34,188	0	34,188	15.00
16.00	Transportation (Health Care Staff)	0	1,105	1,105	0	1,105	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	35,293	35,293	0	35,293	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,515,890	141,559	1,657,449	-6,362	1,651,087	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	5,839	5,839	25.01
25.02	Chronic Care Management	0	0	0	523	523	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	6,362	6,362	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	72,986	72,986	0	72,986	29.00
30.00	Administrative Costs	439,242	188,903	628,145	-228,361	399,784	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	439,242	261,889	701,131	-228,361	472,770	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,955,132	403,448	2,358,580	-228,361	2,130,219	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1304 | Component CCN: 14-3453 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/28/2023 8:47 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	355,959		1.00
2.00	Physician Assistant	0	131,027		2.00
3.00	Nurse Practitioner	0	528,265		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	294,265		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	76,739		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	229,539		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,615,794		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	34,188		15.00
16.00	Transportation (Health Care Staff)	0	1,105		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	35,293		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,651,087		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	5,839		25.01
25.02	Chronic Care Management	0	523		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	6,362		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	72,986		29.00
30.00	Administrative Costs	-6,483	393,301		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-6,483	466,287		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-6,483	2,123,736		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1304 | Component CCN: 14-3453 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-2 | Date/Time Prepared: 11/28/2023 8:47 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.38	4,020	4,200	5,796		1.00
2.00	Physician Assistant	0.90	4,336	2,100	1,890		2.00
3.00	Nurse Practitioner	3.72	12,347	2,100	7,812		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.00	20,703		15,498	20,703	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	0.91	1,643			1,643	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)	6.91	22,346			22,346	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,651,087	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					6,362	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,657,449	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.996162	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					466,287	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					689,525	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,155,812	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,155,812	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,151,376	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,802,463	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1304 Component CCN: 14-3453	Period: From 07/01/2022 To 06/30/2023	Worksheet M-3 Date/Time Prepared: 11/28/2023 8:47 am
	Title XVIII	RHC I	Cost

					1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)				2,802,463	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)				26,603	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)				2,775,860	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)				22,346	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)				0	5.00
6.00	Total adjusted visits (line 4 plus line 5)				22,346	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)				124.22	7.00

		Calculation of Limit (1)		
		Rate Period 1 (07/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 06/30/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	145.03	150.55	8.00
9.00	Rate for Program covered visits (see instructions)	124.22	124.22	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,428	1,490	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	177,386	185,088	11.00
12.00	Program covered visits for mental health services (from contractor records)	2	6	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	248	745	13.00
14.00	Limit adjustment for mental health services (see instructions)	248	745	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	363,467	16.00
16.01	Total program charges (see instructions)(from contractor's records)		697,042	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		131,916	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		68,786	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.)		179,614	16.04
16.05	Total program cost (see instructions)	0	248,400	16.05
17.00	Primary payer amounts		82	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		70,164	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		97,979	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		248,318	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,870	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		254,188	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)		254,188	26.00
26.01	Sequestration adjustment (see instructions)		5,084	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		273,484	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		-24,380	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1304 | Component CCN: 14-3453 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-4 | Date/Time Prepared: 11/28/2023 8:47 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,615,794	1,615,794	1,615,794	1,615,794	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.001653	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	2,671	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	13,002	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	15,673	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,651,087	1,651,087	1,651,087	1,651,087	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,151,376	1,151,376	1,151,376	1,151,376	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.009493	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	10,930	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	26,603	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	358	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	74.31	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	79	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	5,870	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		26,603	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		5,870	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1304 Component CCN: 14-3453	Period: From 07/01/2022 To 06/30/2023	Worksheet M-5 Date/Time Prepared: 11/28/2023 8:47 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		273,484	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		273,484	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		24,380	6.02
7.00	Total Medicare program liability (see instructions)		249,104	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00