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: 14-1331	Period: From 07/01/2022 To 06/30/2023	Worksheet S Parts I-III Date/Time Prepared: 11/27/2023 12:08 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/27/2023 Time: 12:08 pm
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 MARSHALL BROWNING HOSPITAL (14-1331) 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	Harold Calderon		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	Harold Calderon			2
3	Signatory Title	CFO			3
4	Date 11/28/23	(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	93,038	-31,607	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	248,689	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-121,944		0	10.00
10.01	RURAL HEALTH CLINIC II - FHC	0		6,019		0	10.01
200.00	TOTAL	0	341,727	-147,532	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/27/2023 12:08 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 900 NORTH WASHINGTON STREET	PO Box:			1.00
2.00	City: DUQUOIN	State: IL	Zip Code: 62832	County: PERRY	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	MARSHALL BROWNING HOSPITAL	141331	99914	1	01/01/2004	N	O	P	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	MARSHALL BROWNING SWING BED	14Z331	99914		01/01/2004	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	MARSHALL BROWNING PHYSICIAN CLINIC	148504	99914		05/01/2009	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	MARSHAL BROWNING FAMILY HEALTH CENTE	148597	99914		06/28/2018	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	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.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/27/2023 12:08 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	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.	N			57.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1331	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/27/2023 12:08 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
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
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: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/27/2023 12:08 pm

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/27/2023 12:08 pm

			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.	Y	N	Y	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: 14-1331	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/27/2023 12:08 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	307,172	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.	N		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)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			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: 14-1331	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/27/2023 12:08 pm

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	Y	Y	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		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.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	Y	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: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/27/2023 12:08 pm

		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)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	08/26/2022	Y	08/26/2022	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		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: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/27/2023 12:08 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				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?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ANDREW		MCCABE		41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	7158586660		AMCCABE@WIPFLI.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1331	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part II Date/Time Prepared: 11/27/2023 12:08 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CPA		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: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/27/2023 12:08 pm

	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	25	9,125	19,656.00	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)		25	9,125	19,656.00	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)		25	9,125	19,656.00	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
26.01	RURAL HEALTH CLINIC II - FHC	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
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: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/27/2023 12:08 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	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)	576	2	819			1.00
2.00	HMO and other (see instructions)	74	38				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,327	0	1,668			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	251			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,903	2	2,738			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,903	2	2,738	0.00	198.88	14.00
15.00	CAH visits	0	0	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)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	3,757	0	14,393	0.00	19.25	26.00
26.01	RURAL HEALTH CLINIC II - FHC	879	0	3,415	0.00	9.46	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	227.59	27.00
28.00	Observation Bed Days		0	454			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: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/27/2023 12:08 pm

	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	177	1	259	1.00
2.00	HMO and other (see instructions)			18	16		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	177	1	259	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
26.01	RURAL HEALTH CLINIC II - FHC	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1331 | Component CCN: 14-8504 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 11/27/2023 12:08 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			900 N. WASHINGTON		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	DU QUOIN		IL	62832	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					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC					08:00	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		PERRY				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	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1331
Component CCN: 14-8504

Period:
From 07/01/2022
To 06/30/2023

Worksheet S-8

Date/Time Prepared:
11/27/2023 12:08 pm

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:30				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1331 | Component CCN: 14-8597 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 11/27/2023 12:08 pm

RHC II | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street				20 N. WASHINGTON	1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	DU QUION		IL	62832	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			08:00	16:30	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		PERRY				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	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1331
Component CCN: 14-8597

Period:
From 07/01/2022
To 06/30/2023

Worksheet S-8

Date/Time Prepared:
11/27/2023 12:08 pm

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:30				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-10 | Date/Time Prepared: 11/27/2023 12:08 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.491427	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,761,454	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	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	12,544,534	6.00
7.00	Medicaid cost (line 1 times line 6)	6,164,723	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)	1,403,269	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)	1,403,269	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)	271,430	0	271,430	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	133,388	0	133,388	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)	133,388	0	133,388	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)	2,927,327	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	246,546	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	379,301	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,548,026	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,384,924	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,518,312	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,921,581	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/27/2023 12:08 pm

		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		655,201	655,201	290,332	945,533	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		482,298	482,298	-51,212	431,086	2.00
3.00	00300	OTHER CAP REL COSTS		9,142	9,142	-9,142	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,826,015	4,826,015	-199,552	4,626,463	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,266,505	3,187,351	5,453,856	0	5,453,856	5.00
6.00	00600	MAINTENANCE & REPAIRS	362,431	198,678	561,109	0	561,109	6.00
7.00	00700	OPERATION OF PLANT	0	279,975	279,975	0	279,975	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,925	51,023	80,948	0	80,948	8.00
9.00	00900	HOUSEKEEPING	449,045	46,954	495,999	0	495,999	9.00
10.00	01000	DIETARY	409,824	206,593	616,417	0	616,417	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	404,636	14,665	419,301	-32,108	387,193	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	379,750	60,589	440,339	0	440,339	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	390,843	38,646	429,489	0	429,489	16.00
17.00	01700	SOCIAL SERVICE	81,678	10,873	92,551	0	92,551	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	418,500	418,500	0	418,500	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,778,449	986,309	2,764,758	32,108	2,796,866	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	842,705	164,583	1,007,288	39,222	1,046,510	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	741,424	790,210	1,531,634	0	1,531,634	54.00
60.00	06000	LABORATORY	693,598	980,759	1,674,357	0	1,674,357	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	406,615	76,708	483,323	0	483,323	65.00
66.00	06600	PHYSICAL THERAPY	1,064,724	73,672	1,138,396	-325,308	813,088	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	221,448	221,448	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	103,860	103,860	68.00
69.00	06900	ELECTROCARDIOLOGY	32,011	16,065	48,076	0	48,076	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	461,133	461,133	0	461,133	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,302,157	1,302,157	0	1,302,157	73.00
73.01	07301	CARDIAC REHABILITATION	119,014	3,704	122,718	0	122,718	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,616,374	539,703	2,156,077	237,046	2,393,123	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	626,956	88,278	715,234	71,398	786,632	88.01
90.00	09000	CLINIC	443,041	660,431	1,103,472	-28,172	1,075,300	90.00
90.01	09001	EAST MEDICAL CLINIC	0	33,903	33,903	0	33,903	90.01
91.00	09100	EMERGENCY	1,014,663	1,445,000	2,459,663	0	2,459,663	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		396,296	396,296	-396,296	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,154,211	18,505,414	32,659,625	-46,376	32,613,249	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	8,409	8,409	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	121,810	84,223	206,033	37,967	244,000	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	14,276,021	18,589,637	32,865,658	0	32,865,658	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/27/2023 12:08 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-64,856	880,677		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-7,806	423,280		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-13,716	4,612,747		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-760,043	4,693,813		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	561,109		6.00
7.00	00700	OPERATION OF PLANT	0	279,975		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	80,948		8.00
9.00	00900	HOUSEKEEPING	0	495,999		9.00
10.00	01000	DIETARY	-63,905	552,512		10.00
11.00	01100	CAFETERIA	0	0		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	387,193		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	-35,456	404,883		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,410	424,079		16.00
17.00	01700	SOCIAL SERVICE	0	92,551		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	418,500		19.00
20.00	02000	NURSING PROGRAM	0	0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-744,000	2,052,866		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-495,268	551,242		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,531,634		54.00
60.00	06000	LABORATORY	0	1,674,357		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	-16,238	467,085		65.00
66.00	06600	PHYSICAL THERAPY	0	813,088		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	221,448		67.00
68.00	06800	SPEECH PATHOLOGY	-970	102,890		68.00
69.00	06900	ELECTROCARDIOLOGY	0	48,076		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-10,286	450,847		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,302,157		73.00
73.01	07301	CARDIAC REHABILITATION	0	122,718		73.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	2,393,123		88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	786,632		88.01
90.00	09000	CLINIC	-618,992	456,308		90.00
90.01	09001	EAST MEDICAL CLINIC	0	33,903		90.01
91.00	09100	EMERGENCY	0	2,459,663		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,836,946	29,776,303		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	8,409		192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0		192.01
192.02	19202	INDEPENDENT LIVING	0	244,000		192.02
192.03	19203	MEALS ON WHEELS	0	0		192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,836,946	30,028,712		200.00

RECLASSIFICATIONS | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/27/2023 12:08 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	C - TO RECLASS INTEREST EXP					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	390,859		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,437		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		0	396,296		
	F - TO RECLASS DEPRECIATION EXPENSE					
1.00	RURAL HEALTH CLINIC	88.00	0	86,649		1.00
2.00	RURAL HEALTH CLINIC II - FHC	88.01	0	41,702		2.00
3.00	INDEPENDENT LIVING	192.02	0	37,967		3.00
	TOTALS		0	166,318		
	G - RECLASS PT COSTS TO OT & SP					
1.00	OCCUPATIONAL THERAPY	67.00	221,448	0		1.00
2.00	SPEECH PATHOLOGY	68.00	103,530	330		2.00
	TOTALS		324,978	330		
	H - RECLASS PHYSICIAN BENEFITS					
1.00	OPERATING ROOM	50.00	0	39,222		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	130,634		2.00
3.00	RURAL HEALTH CLINIC II - FHC	88.01	0	29,696		3.00
	TOTALS		0	199,552		
	I - RECLASS SPECIALTY CLINIC STAFFING					
1.00	PHYSICIANS PRIVATE OFFICES	192.00	8,409	0		1.00
	TOTALS		8,409	0		
	J - RECLASS IP CHARGE NURSES					
1.00	ADULTS & PEDIATRICS	30.00	32,108	0		1.00
	TOTALS		32,108	0		
	K - RECLASS NURSE TIME TO RHC					
1.00	RURAL HEALTH CLINIC	88.00	17,832	1,931		1.00
	TOTALS		17,832	1,931		
500.00	Grand Total: Increases		383,327	764,427		500.00

RECLASSIFICATIONS | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/27/2023 12:08 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	C - TO RECLASS INTEREST EXP						
1.00	INTEREST EXPENSE	113.00	0	396,296	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
4.00		0.00	0	0	11		4.00
	TOTALS		0	396,296			
	F - TO RECLASS DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	106,694	9		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	59,624	9		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	166,318			
	G - RECLASS PT COSTS TO OT & SP						
1.00	PHYSICAL THERAPY	66.00	324,978	330	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		324,978	330			
	H - RECLASS PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	199,552	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	199,552			
	I - RECLASS SPECIALTY CLINIC STAFFING						
1.00	CLINIC	90.00	8,409	0	0		1.00
	TOTALS		8,409	0			
	J - RECLASS IP CHARGE NURSES						
1.00	NURSING ADMINISTRATION	13.00	32,108	0	0		1.00
	TOTALS		32,108	0			
	K - RECLASS NURSE TIME TO RHC						
1.00	CLINIC	90.00	17,832	1,931	0		1.00
	TOTALS		17,832	1,931			
500.00	Grand Total: Decreases		383,327	764,427			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 11/27/2023 12:08 pm

		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	3,114	0	0	0	0	1.00
2.00	Land Improvements	1,267,104	18,130	0	18,130	0	2.00
3.00	Buildings and Fixtures	8,224,487	15,804	0	15,804	850	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	7,073,458	200,900	0	200,900	112,333	5.00
6.00	Movable Equipment	5,821,213	842,873	0	842,873	348,205	6.00
7.00	HIT designated Assets	1,586,972	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	23,976,348	1,077,707	0	1,077,707	461,388	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	23,976,348	1,077,707	0	1,077,707	461,388	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,114	0	1.00
2.00	Land Improvements	1,285,234	0	2.00
3.00	Buildings and Fixtures	8,239,441	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	7,162,025	0	5.00
6.00	Movable Equipment	6,315,881	0	6.00
7.00	HIT designated Assets	1,586,972	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,592,667	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	24,592,667	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 11/27/2023 12:08 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	655,201	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	482,298	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,137,499	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	655,201	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	482,298	2.00
3.00	Total (sum of lines 1-2)	0	1,137,499	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part III | Date/Time Prepared: 11/27/2023 12:08 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	16,588,700	0	16,588,700	0.674624	6,167	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,000,853	0	8,000,853	0.325376	2,975	2.00
3.00	Total (sum of lines 1-2)	24,589,553	0	24,589,553	1.000000	9,142	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	6,167	543,535	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2,975	415,717	0	2.00
3.00	Total (sum of lines 1-2)	0	0	9,142	959,252	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	330,975	6,167	0	0	880,677	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,588	2,975	0	0	423,280	2.00
3.00	Total (sum of lines 1-2)	335,563	9,142	0	0	1,303,957	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/27/2023 12:08 pm

	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)	B	-60,999	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-849	CAP REL COSTS-MVBLE EQUIP	2.00	11	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	-10,286	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,874,498			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-59,555	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-35,456	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,410	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		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

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/27/2023 12:08 pm

	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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-832	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-28,601	ADMINISTRATIVE & GENERAL	5.00	0	33.00
36.00	IHA/AHA DUES USED FOR LOBBYING	A	-8,913	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	MARKETING	A	-133,539	ADMINISTRATIVE & GENERAL	5.00	0	37.00
41.00	DEPRECIATION	A	-4,972	CAP REL COSTS-BLDG & FIXT	1.00	9	41.00
43.00	DEPRECIATION	A	-6,125	CAP REL COSTS-MVBLE EQUIP	2.00	9	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.00
46.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	46.00
47.00	PROVIDER TAX ASSESSMENT	A	-588,990	ADMINISTRATIVE & GENERAL	5.00	0	47.00
47.01	DIABETES EDUCATION	B	-4,350	DIETARY	10.00	0	47.01
47.02	CONTRACTED THERAPY EXPENSES	A	-970	SPEECH PATHOLOGY	68.00	0	47.02
47.03	POST RETIREMENT BENEFITS PAID	B	-13,716	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	47.03
47.04	LAPSE BACK LOSS ON REFINANCING IN 23	A	1,115	CAP REL COSTS-BLDG & FIXT	1.00	11	47.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,836,946				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 11/27/2023 12:08 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	744,000	744,000	0	0	0	1.00
2.00	91.00	EMERGENCY	1,241,445	0	1,241,445	0	0	2.00
3.00	60.00	LABORATORY	26,138	0	26,138	0	0	3.00
4.00	50.00	OPERATING ROOM	495,268	495,268	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	16,238	16,238	0	0	0	5.00
6.00	90.00	CLINIC	618,992	618,992	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			3,142,081	1,874,498	1,267,583		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	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	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	744,000		1.00
2.00	91.00	EMERGENCY	0	0	0	0		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	50.00	OPERATING ROOM	0	0	0	495,268		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	16,238		5.00
6.00	90.00	CLINIC	0	0	0	618,992		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	1,874,498		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/27/2023 12:08 pm

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					47	1.00
2.00	Line 1 multiplied by 15 hours per week					705	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					90	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					6.20	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	708.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	93.32	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)	46.66	46.66	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)					66,094	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)					66,094	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)					66,094	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)					66,094	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)					4,199	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					4,199	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					558	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					4,757	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)					4,757	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/27/2023 12:08 pm

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	93.32	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)	66,094		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	4,757		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)	70,851		63.00
64.00	Total cost of outside supplier services (from your records)	49,540		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	4,199		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	558		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	4,757		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	558		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	558		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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/27/2023 12:08 pm

		Speech Pathology	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		2	1.00
2.00	Line 1 multiplied by 15 hours per week		30	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		3	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)		3	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		6.20	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	5.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	84.98	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)	42.49	42.49	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)		467	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)		467	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)		467	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)		84.91	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		2,547	22.00
23.00	Total salary equivalency (see instructions)		2,547	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)		127	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)		127	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)		37	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		164	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)		164	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/27/2023 12:08 pm

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	84.98	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)	2,547		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	164		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)	2,711		63.00
64.00	Total cost of outside supplier services (from your records)	330		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	127		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	37		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	164		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	37		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	37		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: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/27/2023 12:08 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	880,677	880,677				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	423,280		423,280			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,612,747	0	0	4,612,747		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,693,813	227,963	110,731	838,851	5,871,358	5.00
6.00	00600	MAINTENANCE & REPAIRS	561,109	0	0	134,139	695,248	6.00
7.00	00700	OPERATION OF PLANT	279,975	78,244	38,006	0	396,225	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	80,948	29,810	14,480	11,075	136,313	8.00
9.00	00900	HOUSEKEEPING	495,999	17,002	8,259	166,195	687,455	9.00
10.00	01000	DIETARY	552,512	46,325	22,502	151,679	773,018	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	387,193	8,660	4,206	137,876	537,935	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	404,883	13,466	6,541	140,549	565,439	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	424,079	18,714	9,090	144,654	596,537	16.00
17.00	01700	SOCIAL SERVICE	92,551	1,836	892	30,230	125,509	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	418,500	0	0	0	418,500	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,052,866	137,774	66,922	670,102	2,927,664	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	551,242	62,738	30,474	132,614	777,068	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,531,634	19,088	9,272	274,407	1,834,401	54.00
60.00	06000	LABORATORY	1,674,357	27,816	13,511	256,706	1,972,390	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	467,085	29,028	14,100	150,491	660,704	65.00
66.00	06600	PHYSICAL THERAPY	813,088	38,890	18,890	273,786	1,144,654	66.00
67.00	06700	OCCUPATIONAL THERAPY	221,448	7,300	3,546	81,960	314,254	67.00
68.00	06800	SPEECH PATHOLOGY	102,890	1,598	776	38,317	143,581	68.00
69.00	06900	ELECTROCARDIOLOGY	48,076	850	413	11,848	61,187	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	450,847	0	0	0	450,847	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,302,157	0	0	0	1,302,157	73.00
73.01	07301	CARDIAC REHABILITATION	122,718	7,515	3,650	44,048	177,931	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,393,123	0	0	209,317	2,602,440	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	786,632	0	0	135,912	922,544	88.01
90.00	09000	CLINIC	456,308	55,008	26,719	154,261	692,296	90.00
90.01	09001	EAST MEDICAL CLINIC	33,903	0	0	0	33,903	90.01
91.00	09100	EMERGENCY	2,459,663	35,682	17,332	375,535	2,888,212	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,776,303	865,307	420,312	4,564,552	29,709,770	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	9,261	0	0	9,261	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	8,409	6,109	2,968	3,112	20,598	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	244,000	0	0	45,083	289,083	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	30,028,712	880,677	423,280	4,612,747	30,028,712	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/27/2023 12:08 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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
5.00	00500	ADMINISTRATIVE & GENERAL	5,871,358					5.00
6.00	00600	MAINTENANCE & REPAIRS	168,977	864,225				6.00
7.00	00700	OPERATION OF PLANT	96,301	90,216	582,742			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,130	34,372	30,240	234,055		8.00
9.00	00900	HOUSEKEEPING	167,083	19,604	17,247	0	891,389	9.00
10.00	01000	DIETARY	187,879	53,414	46,992	0	67,121	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	130,743	9,985	8,784	0	12,547	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	137,428	15,526	13,660	0	19,510	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	144,986	21,577	18,983	0	27,114	16.00
17.00	01700	SOCIAL SERVICE	30,504	2,117	1,863	0	2,661	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	101,715	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	711,568	158,855	139,759	234,055	199,622	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	188,863	72,338	63,641	0	90,901	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	445,844	22,008	19,363	0	27,656	54.00
60.00	06000	LABORATORY	479,381	32,072	28,216	0	40,302	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	160,581	33,470	29,446	0	42,059	65.00
66.00	06600	PHYSICAL THERAPY	278,204	44,840	39,450	0	56,347	66.00
67.00	06700	OCCUPATIONAL THERAPY	76,378	8,417	7,405	0	10,576	67.00
68.00	06800	SPEECH PATHOLOGY	34,897	1,843	1,621	0	2,316	68.00
69.00	06900	ELECTROCARDIOLOGY	14,871	980	862	0	1,232	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	109,577	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	316,484	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	43,245	8,665	7,623	0	10,888	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	632,513	79,722	0	0	100,180	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	224,221	31,915	0	0	40,105	88.01
90.00	09000	CLINIC	168,260	63,425	55,800	0	79,701	90.00
90.01	09001	EAST MEDICAL CLINIC	8,240	0	0	0	0	90.01
91.00	09100	EMERGENCY	701,968	41,142	36,196	0	51,699	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,793,841	846,503	567,151	234,055	882,537	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	2,251	10,678	9,394	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	5,006	7,044	6,197	0	8,852	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	70,260	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	5,871,358	864,225	582,742	234,055	891,389	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/27/2023 12:08 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,128,424					10.00
11.00	01100	CAFETERIA	0	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	699,994		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	10,762	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,128,424	0	0	238,551	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	47,210	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	53,574	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	97,467	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	29,177	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	13,641	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,218	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	0	15,681	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	54,916	0	90.00
90.01	09001	EAST MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	133,689	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,128,424	0	0	698,886	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	1,108	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,128,424	0	0	699,994	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/27/2023 12:08 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
		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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	751,563					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	809,197				16.00
17.00	01700	SOCIAL SERVICE	0	0	173,416			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	520,215		19.00
20.00	02000	NURSING PROGRAM	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	87,375	173,416	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	28,642	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	9,222	0	520,215	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	177,993	0	0	0	54.00
60.00	06000	LABORATORY	0	154,867	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	36,082	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	38,191	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,955	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,776	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	12,255	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	40,055	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	751,563	74,505	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0	3,791	0	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	61,750	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	7,676	0	0	0	88.01
90.00	09000	CLINIC	0	5,465	0	0	0	90.00
90.01	09001	EAST MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	56,597	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	751,563	809,197	173,416	520,215	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	751,563	809,197	173,416	520,215	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/27/2023 12:08 pm

		Cost Center Description	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	5,999,289	0	5,999,289	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	1,268,663	0	1,268,663	50.00
53.00	05300	ANESTHESIOLOGY	0	0	529,437	0	529,437	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,527,265	0	2,527,265	54.00
60.00	06000	LABORATORY	0	0	2,707,228	0	2,707,228	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	1,015,916	0	1,015,916	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,699,153	0	1,699,153	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	458,162	0	458,162	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	200,675	0	200,675	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	95,605	0	95,605	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	600,479	0	600,479	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,444,709	0	2,444,709	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	267,824	0	267,824	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	3,476,605	0	3,476,605	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	1,226,461	0	1,226,461	88.01
90.00	09000	CLINIC	0	0	1,119,863	0	1,119,863	90.00
90.01	09001	EAST MEDICAL CLINIC	0	0	42,143	0	42,143	90.01
91.00	09100	EMERGENCY	0	0	3,909,503	0	3,909,503	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	29,588,980	0	29,588,980	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	31,584	0	31,584	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	48,805	0	48,805	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	359,343	0	359,343	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	30,028,712	0	30,028,712	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/27/2023 12:08 pm

		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
5.00	00500	ADMINISTRATIVE & GENERAL	0	227,963	110,731	338,694	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	78,244	38,006	116,250	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	29,810	14,480	44,290	0	8.00
9.00	00900	HOUSEKEEPING	0	17,002	8,259	25,261	0	9.00
10.00	01000	DIETARY	0	46,325	22,502	68,827	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	8,660	4,206	12,866	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	13,466	6,541	20,007	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,714	9,090	27,804	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,836	892	2,728	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	137,774	66,922	204,696	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	62,738	30,474	93,212	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,088	9,272	28,360	0	54.00
60.00	06000	LABORATORY	0	27,816	13,511	41,327	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	29,028	14,100	43,128	0	65.00
66.00	06600	PHYSICAL THERAPY	0	38,890	18,890	57,780	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,300	3,546	10,846	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,598	776	2,374	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	850	413	1,263	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0	7,515	3,650	11,165	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	55,008	26,719	81,727	0	90.00
90.01	09001	EAST MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	35,682	17,332	53,014	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	865,307	420,312	1,285,619	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	9,261	0	9,261	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	6,109	2,968	9,077	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	0	880,677	423,280	1,303,957	0	202.00

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		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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
5.00	00500	ADMINISTRATIVE & GENERAL	338,694					5.00
6.00	00600	MAINTENANCE & REPAIRS	9,747	9,747				6.00
7.00	00700	OPERATION OF PLANT	5,555	1,017	122,822			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,911	388	6,374	52,963		8.00
9.00	00900	HOUSEKEEPING	9,638	221	3,635	0	38,755	9.00
10.00	01000	DIETARY	10,838	602	9,904	0	2,918	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	7,542	113	1,851	0	546	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	7,927	175	2,879	0	848	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,363	243	4,001	0	1,179	16.00
17.00	01700	SOCIAL SERVICE	1,760	24	393	0	116	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	5,867	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,055	1,793	29,455	52,963	8,677	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,894	816	13,413	0	3,952	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,718	248	4,081	0	1,202	54.00
60.00	06000	LABORATORY	27,653	362	5,947	0	1,752	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	9,263	377	6,206	0	1,829	65.00
66.00	06600	PHYSICAL THERAPY	16,048	506	8,315	0	2,450	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,406	95	1,561	0	460	67.00
68.00	06800	SPEECH PATHOLOGY	2,013	21	342	0	101	68.00
69.00	06900	ELECTROCARDIOLOGY	858	11	182	0	54	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,321	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,256	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	2,495	98	1,607	0	473	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	36,486	899	0	0	4,356	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	12,934	360	0	0	1,744	88.01
90.00	09000	CLINIC	9,706	715	11,761	0	3,465	90.00
90.01	09001	EAST MEDICAL CLINIC	475	0	0	0	0	90.01
91.00	09100	EMERGENCY	40,493	464	7,629	0	2,248	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	334,222	9,548	119,536	52,963	38,370	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	130	120	1,980	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	289	79	1,306	0	385	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	4,053	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	338,694	9,747	122,822	52,963	38,755	202.00

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		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	93,089					10.00
11.00	01100	CAFETERIA	0	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	22,918		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	352	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	93,089	0	0	7,811	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,546	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,754	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,191	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	955	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	447	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	138	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	0	513	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	1,798	0	90.00
90.01	09001	EAST MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	4,377	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	93,089	0	0	22,882	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	36	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	93,089	0	0	22,918	0	202.00

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		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
		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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	31,836					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	41,590				16.00
17.00	01700	SOCIAL SERVICE	0	0	5,373			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	5,867		19.00
20.00	02000	NURSING PROGRAM	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,492	5,373			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,473	0			50.00
53.00	05300	ANESTHESIOLOGY	0	474	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,136	0			54.00
60.00	06000	LABORATORY	0	7,962	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	1,855	0			65.00
66.00	06600	PHYSICAL THERAPY	0	1,964	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	615	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	143	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	630	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,059	0			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,836	3,831	0			73.00
73.01	07301	CARDIAC REHABILITATION	0	195	0			73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,175	0			88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	395	0			88.01
90.00	09000	CLINIC	0	281	0			90.00
90.01	09001	EAST MEDICAL CLINIC	0	0	0			90.01
91.00	09100	EMERGENCY	0	2,910	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,836	41,590	5,373	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0			190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0			192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0			192.01
192.02	19202	INDEPENDENT LIVING	0	0	0			192.02
192.03	19203	MEALS ON WHEELS	0	0	0			192.03
200.00		Cross Foot Adjustments				5,867	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	31,836	41,590	5,373	5,867	0	202.00

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		Cost Center Description	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS			449,404	0	449,404	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM			125,306	0	125,306	50.00
53.00	05300	ANESTHESIOLOGY			474	0	474	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			68,745	0	68,745	54.00
60.00	06000	LABORATORY			85,003	0	85,003	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS			0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY			64,412	0	64,412	65.00
66.00	06600	PHYSICAL THERAPY			90,254	0	90,254	66.00
67.00	06700	OCCUPATIONAL THERAPY			18,938	0	18,938	67.00
68.00	06800	SPEECH PATHOLOGY			5,441	0	5,441	68.00
69.00	06900	ELECTROCARDIOLOGY			3,136	0	3,136	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT			8,380	0	8,380	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS			53,923	0	53,923	73.00
73.01	07301	CARDIAC REHABILITATION			16,546	0	16,546	73.01
76.97	07697	CARDIAC REHABILITATION			0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY			0	0	0	76.98
76.99	07699	LITHOTRIPSY			0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC			44,916	0	44,916	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC			15,433	0	15,433	88.01
90.00	09000	CLINIC			109,453	0	109,453	90.00
90.01	09001	EAST MEDICAL CLINIC			475	0	475	90.01
91.00	09100	EMERGENCY			111,135	0	111,135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	1,271,374	0	1,271,374	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN			11,491	0	11,491	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES			11,172	0	11,172	192.00
192.01	19201	FAMILY MEDICAL CLINIC			0	0	0	192.01
192.02	19202	INDEPENDENT LIVING			4,053	0	4,053	192.02
192.03	19203	MEALS ON WHEELS			0	0	0	192.03
200.00		Cross Foot Adjustments	0	0	5,867	0	5,867	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	1,303,957	0	1,303,957	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/27/2023 12:08 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	77,697					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		76,880				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	12,463,245			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,112	20,112	2,266,505	-5,871,358	24,157,354	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	362,431	0	695,248	6.00
7.00	00700	OPERATION OF PLANT	6,903	6,903	0	0	396,225	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,630	2,630	29,925	0	136,313	8.00
9.00	00900	HOUSEKEEPING	1,500	1,500	449,045	0	687,455	9.00
10.00	01000	DIETARY	4,087	4,087	409,824	0	773,018	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	764	764	372,528	0	537,935	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,188	1,188	379,750	0	565,439	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,651	1,651	390,843	0	596,537	16.00
17.00	01700	SOCIAL SERVICE	162	162	81,678	0	125,509	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	418,500	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,155	12,155	1,810,557	0	2,927,664	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,535	5,535	358,311	0	777,068	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,684	1,684	741,424	0	1,834,401	54.00
60.00	06000	LABORATORY	2,454	2,454	693,598	0	1,972,390	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,561	2,561	406,615	0	660,704	65.00
66.00	06600	PHYSICAL THERAPY	3,431	3,431	739,746	0	1,144,654	66.00
67.00	06700	OCCUPATIONAL THERAPY	644	644	221,448	0	314,254	67.00
68.00	06800	SPEECH PATHOLOGY	141	141	103,530	0	143,581	68.00
69.00	06900	ELECTROCARDIOLOGY	75	75	32,011	0	61,187	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	450,847	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,302,157	73.00
73.01	07301	CARDIAC REHABILITATION	663	663	119,014	0	177,931	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	565,557	0	2,602,440	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	367,223	0	922,544	88.01
90.00	09000	CLINIC	4,853	4,853	416,800	0	692,296	90.00
90.01	09001	EAST MEDICAL CLINIC	0	0	0	0	33,903	90.01
91.00	09100	EMERGENCY	3,148	3,148	1,014,663	0	2,888,212	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,341	76,341	12,333,026	-5,871,358	23,838,412	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	817	0	0	0	9,261	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	539	539	8,409	0	20,598	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	121,810	0	289,083	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	880,677	423,280	4,612,747		5,871,358	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.334762	5.505723	0.370108		0.243046	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		338,694	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.014020	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: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/27/2023 12:08 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
		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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	66,127					6.00
7.00	00700	OPERATION OF PLANT	6,903	50,682				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,630	2,630	3,192			8.00
9.00	00900	HOUSEKEEPING	1,500	1,500	0	54,277		9.00
10.00	01000	DIETARY	4,087	4,087	0	4,087	3,192	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	764	764	0	764	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,188	1,188	0	1,188	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,651	1,651	0	1,651	0	16.00
17.00	01700	SOCIAL SERVICE	162	162	0	162	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,155	12,155	3,192	12,155	3,192	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,535	5,535	0	5,535	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,684	1,684	0	1,684	0	54.00
60.00	06000	LABORATORY	2,454	2,454	0	2,454	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,561	2,561	0	2,561	0	65.00
66.00	06600	PHYSICAL THERAPY	3,431	3,431	0	3,431	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	644	644	0	644	0	67.00
68.00	06800	SPEECH PATHOLOGY	141	141	0	141	0	68.00
69.00	06900	ELECTROCARDIOLOGY	75	75	0	75	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	663	663	0	663	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,100	0	0	6,100	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	2,442	0	0	2,442	0	88.01
90.00	09000	CLINIC	4,853	4,853	0	4,853	0	90.00
90.01	09001	EAST MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	3,148	3,148	0	3,148	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	64,771	49,326	3,192	53,738	3,192	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	817	817	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	539	539	0	539	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	864,225	582,742	234,055	891,389	1,128,424	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.069170	11.498007	73.325501	16.422960	353.516291	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,747	122,822	52,963	38,755	93,089	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.147398	2.423385	16.592419	0.714023	29.163221	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: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/27/2023 12:08 pm

		Cost Center Description	CAFETERIA (GROSS SALARIES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
		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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	0	0	5,312,782			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	0	0	0	1,302,157	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	81,678	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,810,557	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	358,311	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	406,615	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	739,746	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	221,448	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	103,530	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	32,011	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,302,157	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	119,014	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	416,800	0	0	90.00
90.01	09001	EAST MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	1,014,663	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	5,304,373	0	1,302,157	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	8,409	0	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	0	0	699,994	0	751,563	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	0.131757	0.000000	0.577168	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	22,918	0	31,836	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.004314	0.000000	0.024449	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: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/27/2023 12:08 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
		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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	60,210,283					16.00
17.00	01700	SOCIAL SERVICE	0	100				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	100			19.00
20.00	02000	NURSING PROGRAM	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,501,105	100	0	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,131,117	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	686,141	0	100	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,245,714	0	0	0	0	54.00
60.00	06000	LABORATORY	11,522,818	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,684,660	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,841,571	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	889,515	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	206,530	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	911,829	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,980,301	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,543,536	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	282,055	0	0	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,594,527	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	571,111	0	0	0	0	88.01
90.00	09000	CLINIC	406,631	0	0	0	0	90.00
90.01	09001	EAST MEDICAL CLINIC	1	0	0	0	0	90.01
91.00	09100	EMERGENCY	4,211,121	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	60,210,283	100	100	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FAMILY MEDICAL CLINIC	0	0	0	0	0	192.01
192.02	19202	INDEPENDENT LIVING	0	0	0	0	0	192.02
192.03	19203	MEALS ON WHEELS	0	0	0	0	0	192.03
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)	809,197	173,416	520,215	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.013440	1,734.160000	5,202.150000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	41,590	5,373	5,867	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000691	53.730000	58.670000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/27/2023 12:08 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00		
		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
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
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
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
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
20.00	02000	NURSING PROGRAM			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
73.01	07301	CARDIAC REHABILITATION	0		73.01
76.97	07697	CARDIAC REHABILITATION	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		76.98
76.99	07699	LITHOTRIPSY	0		76.99
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0		88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0		88.01
90.00	09000	CLINIC	0		90.00
90.01	09001	EAST MEDICAL CLINIC	0		90.01
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		192.00
192.01	19201	FAMILY MEDICAL CLINIC	0		192.01
192.02	19202	INDEPENDENT LIVING	0		192.02
192.03	19203	MEALS ON WHEELS	0		192.03
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)	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/27/2023 12:08 pm

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	5,999,289		5,999,289	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,268,663		1,268,663	0	0	50.00
53.00	05300	ANESTHESIOLOGY	529,437		529,437	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,527,265		2,527,265	0	0	54.00
60.00	06000	LABORATORY	2,707,228		2,707,228	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,015,916	0	1,015,916	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,699,153	0	1,699,153	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	458,162	0	458,162	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	200,675	0	200,675	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	95,605		95,605	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	600,479		600,479	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,444,709		2,444,709	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	267,824		267,824	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,476,605		3,476,605	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	1,226,461		1,226,461	0	0	88.01
90.00	09000	CLINIC	1,119,863		1,119,863	0	0	90.00
90.01	09001	EAST MEDICAL CLINIC	42,143		42,143	0	0	90.01
91.00	09100	EMERGENCY	3,909,503		3,909,503	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	918,242		918,242		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	30,507,222	0	30,507,222	0	0	200.00
201.00		Less Observation Beds	918,242		918,242		0	201.00
202.00		Total (see instructions)	29,588,980	0	29,588,980	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/27/2023 12:08 pm

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	1,732,517		1,732,517			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	130,053	2,001,064	2,131,117	0.595304	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	16,523	669,618	686,141	0.771615	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	474,414	12,771,300	13,245,714	0.190799	0.000000	54.00
60.00	06000	LABORATORY	1,207,208	10,315,610	11,522,818	0.234945	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	1,345,868	1,338,792	2,684,660	0.378415	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	333,828	2,507,743	2,841,571	0.597963	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	301,332	588,183	889,515	0.515069	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	8,178	198,352	206,530	0.971651	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	31,098	880,731	911,829	0.104850	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,013,751	1,966,550	2,980,301	0.201483	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,362,868	4,180,668	5,543,536	0.441002	0.000000	73.00
73.01	07301	CARDIAC REHABILITATION	0	282,055	282,055	0.949545	0.000000	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,594,527	4,594,527			88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	571,111	571,111			88.01
90.00	09000	CLINIC	0	406,631	406,631	2.754003	0.000000	90.00
90.01	09001	EAST MEDICAL CLINIC	0	1	1	42,143.000000	0.000000	90.01
91.00	09100	EMERGENCY	5,349	4,205,772	4,211,121	0.928376	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	134,466	4,634,122	4,768,588	0.192561	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	8,097,453	52,112,830	60,210,283			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,097,453	52,112,830	60,210,283			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/27/2023 12:08 pm

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
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301	CARDIAC REHABILITATION	0.000000		73.01
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC			88.01
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	EAST MEDICAL CLINIC	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/27/2023 12:08 pm

Title XIX | Hospital | PPS

		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	5,999,289		5,999,289	0	5,999,289	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,268,663		1,268,663	0	1,268,663	50.00
53.00	05300	ANESTHESIOLOGY	529,437		529,437	0	529,437	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,527,265		2,527,265	0	2,527,265	54.00
60.00	06000	LABORATORY	2,707,228		2,707,228	0	2,707,228	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,015,916	0	1,015,916	0	1,015,916	65.00
66.00	06600	PHYSICAL THERAPY	1,699,153	0	1,699,153	0	1,699,153	66.00
67.00	06700	OCCUPATIONAL THERAPY	458,162	0	458,162	0	458,162	67.00
68.00	06800	SPEECH PATHOLOGY	200,675	0	200,675	0	200,675	68.00
69.00	06900	ELECTROCARDIOLOGY	95,605		95,605	0	95,605	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	600,479		600,479	0	600,479	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,444,709		2,444,709	0	2,444,709	73.00
73.01	07301	CARDIAC REHABILITATION	267,824		267,824	0	267,824	73.01
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,476,605		3,476,605	0	3,476,605	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	1,226,461		1,226,461	0	1,226,461	88.01
90.00	09000	CLINIC	1,119,863		1,119,863	0	1,119,863	90.00
90.01	09001	EAST MEDICAL CLINIC	42,143		42,143	0	42,143	90.01
91.00	09100	EMERGENCY	3,909,503		3,909,503	0	3,909,503	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	918,242		918,242		918,242	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	30,507,222	0	30,507,222	0	30,507,222	200.00
201.00		Less Observation Beds	918,242		918,242		918,242	201.00
202.00		Total (see instructions)	29,588,980	0	29,588,980	0	29,588,980	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/27/2023 12:08 pm

Title XIX | Hospital | PPS

		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	1,732,517		1,732,517			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	130,053	2,001,064	2,131,117	0.595304	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	16,523	669,618	686,141	0.771615	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	474,414	12,771,300	13,245,714	0.190799	0.000000	54.00
60.00	06000	LABORATORY	1,207,208	10,315,610	11,522,818	0.234945	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	1,345,868	1,338,792	2,684,660	0.378415	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	333,828	2,507,743	2,841,571	0.597963	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	301,332	588,183	889,515	0.515069	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	8,178	198,352	206,530	0.971651	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	31,098	880,731	911,829	0.104850	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,013,751	1,966,550	2,980,301	0.201483	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,362,868	4,180,668	5,543,536	0.441002	0.000000	73.00
73.01	07301	CARDIAC REHABILITATION	0	282,055	282,055	0.949545	0.000000	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,594,527	4,594,527	0.756684	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	571,111	571,111	2.147500	0.000000	88.01
90.00	09000	CLINIC	0	406,631	406,631	2.754003	0.000000	90.00
90.01	09001	EAST MEDICAL CLINIC	0	1	1	42,143.000000	0.000000	90.01
91.00	09100	EMERGENCY	5,349	4,205,772	4,211,121	0.928376	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	134,466	4,634,122	4,768,588	0.192561	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	8,097,453	52,112,830	60,210,283			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,097,453	52,112,830	60,210,283			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/27/2023 12:08 pm

Title XIX | Hospital | PPS

		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	0.595304		50.00
53.00	05300	ANESTHESIOLOGY	0.771615		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190799		54.00
60.00	06000	LABORATORY	0.234945		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.378415		65.00
66.00	06600	PHYSICAL THERAPY	0.597963		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.515069		67.00
68.00	06800	SPEECH PATHOLOGY	0.971651		68.00
69.00	06900	ELECTROCARDIOLOGY	0.104850		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.201483		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.441002		73.00
73.01	07301	CARDIAC REHABILITATION	0.949545		73.01
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.756684		88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	2.147500		88.01
90.00	09000	CLINIC	2.754003		90.00
90.01	09001	EAST MEDICAL CLINIC	42,143.000000		90.01
91.00	09100	EMERGENCY	0.928376		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.192561		92.00
		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

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part II | Date/Time Prepared: 11/27/2023 12:08 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,268,663	125,306	1,143,357	0	0	50.00
53.00	05300	ANESTHESIOLOGY	529,437	474	528,963	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,527,265	68,745	2,458,520	0	0	54.00
60.00	06000	LABORATORY	2,707,228	85,003	2,622,225	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,015,916	64,412	951,504	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,699,153	90,254	1,608,899	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	458,162	18,938	439,224	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	200,675	5,441	195,234	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	95,605	3,136	92,469	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	600,479	8,380	592,099	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,444,709	53,923	2,390,786	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	267,824	16,546	251,278	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,476,605	44,916	3,431,689	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	1,226,461	15,433	1,211,028	0	0	88.01
90.00	09000	CLINIC	1,119,863	109,453	1,010,410	0	0	90.00
90.01	09001	EAST MEDICAL CLINIC	42,143	475	41,668	0	0	90.01
91.00	09100	EMERGENCY	3,909,503	111,135	3,798,368	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	918,242	68,786	849,456	0	0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	24,507,933	890,756	23,617,177	0	0	200.00
201.00		Less Observation Beds	918,242	68,786	849,456	0	0	201.00
202.00		Total (line 200 minus line 201)	23,589,691	821,970	22,767,721	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part II | Date/Time Prepared: 11/27/2023 12:08 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,268,663	2,131,117	0.595304		50.00
53.00	05300	ANESTHESIOLOGY	529,437	686,141	0.771615		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,527,265	13,245,714	0.190799		54.00
60.00	06000	LABORATORY	2,707,228	11,522,818	0.234945		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	1,015,916	2,684,660	0.378415		65.00
66.00	06600	PHYSICAL THERAPY	1,699,153	2,841,571	0.597963		66.00
67.00	06700	OCCUPATIONAL THERAPY	458,162	889,515	0.515069		67.00
68.00	06800	SPEECH PATHOLOGY	200,675	206,530	0.971651		68.00
69.00	06900	ELECTROCARDIOLOGY	95,605	911,829	0.104850		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	600,479	2,980,301	0.201483		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,444,709	5,543,536	0.441002		73.00
73.01	07301	CARDIAC REHABILITATION	267,824	282,055	0.949545		73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000		76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	3,476,605	4,594,527	0.756684		88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	1,226,461	571,111	2.147500		88.01
90.00	09000	CLINIC	1,119,863	406,631	2.754003		90.00
90.01	09001	EAST MEDICAL CLINIC	42,143	1	42,143.000000		90.01
91.00	09100	EMERGENCY	3,909,503	4,211,121	0.928376		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	918,242	4,768,588	0.192561		92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	24,507,933	58,477,766			200.00
201.00		Less Observation Beds	918,242	0			201.00
202.00		Total (line 200 minus line 201)	23,589,691	58,477,766			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 11/27/2023 12:08 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	125,306	2,131,117	0.058798	118,172	6,948	50.00
53.00	05300	ANESTHESIOLOGY	474	686,141	0.000691	11,478	8	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	68,745	13,245,714	0.005190	261,910	1,359	54.00
60.00	06000	LABORATORY	85,003	11,522,818	0.007377	414,674	3,059	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	64,412	2,684,660	0.023993	320,749	7,696	65.00
66.00	06600	PHYSICAL THERAPY	90,254	2,841,571	0.031762	35,709	1,134	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,938	889,515	0.021290	18,404	392	67.00
68.00	06800	SPEECH PATHOLOGY	5,441	206,530	0.026345	2,292	60	68.00
69.00	06900	ELECTROCARDIOLOGY	3,136	911,829	0.003439	12,493	43	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,380	2,980,301	0.002812	364,934	1,026	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	53,923	5,543,536	0.009727	333,182	3,241	73.00
73.01	07301	CARDIAC REHABILITATION	16,546	282,055	0.058662	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	44,916	4,594,527	0.009776	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	15,433	571,111	0.027023	0	0	88.01
90.00	09000	CLINIC	109,453	406,631	0.269170	0	0	90.00
90.01	09001	EAST MEDICAL CLINIC	475	1	475.000000	0	0	90.01
91.00	09100	EMERGENCY	111,135	4,211,121	0.026391	4,868	128	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	68,786	4,768,588	0.014425	66,576	960	92.00
200.00		Total (lines 50 through 199)	890,756	58,477,766		1,965,441	26,054	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/27/2023 12:08 pm

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	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	520,215	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	0	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	EAST MEDICAL CLINIC	0	0	0	0	0	90.01
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)	520,215	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/27/2023 12:08 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	2,131,117	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	520,215	0	686,141	0.758175	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,245,714	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	11,522,818	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,684,660	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,841,571	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	889,515	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	206,530	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	911,829	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,980,301	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,543,536	0.000000	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	0	282,055	0.000000	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,594,527	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	571,111	0.000000	88.01
90.00	09000	CLINIC	0	0	0	406,631	0.000000	90.00
90.01	09001	EAST MEDICAL CLINIC	0	0	0	1	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	4,211,121	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,768,588	0.000000	92.00
200.00		Total (lines 50 through 199)	0	520,215	0	58,477,766		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/27/2023 12:08 pm

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	118,172	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	11,478	8,702	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	261,910	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	414,674	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	320,749	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	35,709	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	18,404	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,292	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	12,493	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	364,934	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	333,182	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0.000000	0	0	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	EAST MEDICAL CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	4,868	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	66,576	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,965,441	8,702	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/27/2023 12:08 pm

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	0.595304	0	528,908	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.771615	0	241,493	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190799	0	4,131,612	0	0	54.00
60.00	06000	LABORATORY	0.234945	0	3,491,365	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.378415	0	437,324	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.597963	0	919,585	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.515069	0	128,725	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.971651	0	9,037	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.104850	0	282,422	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.201483	0	502,441	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.441002	0	2,428,042	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0.949545	0	123,876	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC						88.01
90.00	09000	CLINIC	2.754003	0	155,765	0	0	90.00
90.01	09001	EAST MEDICAL CLINIC	42,143.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.928376	0	1,008,220	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.192561	0	1,551,369	0	0	92.00
200.00		Subtotal (see instructions)		0	15,940,184	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	15,940,184	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/27/2023 12:08 pm

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	314,861	0		50.00
53.00	05300	ANESTHESIOLOGY	186,340	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	788,307	0		54.00
60.00	06000	LABORATORY	820,279	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	165,490	0		65.00
66.00	06600	PHYSICAL THERAPY	549,878	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	66,302	0		67.00
68.00	06800	SPEECH PATHOLOGY	8,781	0		68.00
69.00	06900	ELECTROCARDIOLOGY	29,612	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	101,233	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,070,771	0		73.00
73.01	07301	CARDIAC REHABILITATION	117,626	0		73.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC				88.01
90.00	09000	CLINIC	428,977	0		90.00
90.01	09001	EAST MEDICAL CLINIC	0	0		90.01
91.00	09100	EMERGENCY	936,007	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	298,733	0		92.00
200.00		Subtotal (see instructions)	5,883,197	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,883,197	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1331 | Component CCN: 14-Z331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V | Date/Time Prepared: 11/27/2023 12:08 pm

Title XVIII | Swing Beds - SNF | 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	0.595304	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.771615	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190799	0	0	0	0	54.00
60.00	06000	LABORATORY	0.234945	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.378415	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.597963	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.515069	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.971651	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.104850	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.201483	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.441002	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0.949545	0	0	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC						88.01
90.00	09000	CLINIC	2.754003	0	0	0	0	90.00
90.01	09001	EAST MEDICAL CLINIC	42,143.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.928376	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.192561	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1331 | Component CCN: 14-Z331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V | Date/Time Prepared: 11/27/2023 12:08 pm

Title XVIII | Swing Beds - SNF | 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	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC			88.01
90.00	09000	CLINIC	0	0	90.00
90.01	09001	EAST MEDICAL CLINIC	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part I | Date/Time Prepared: 11/27/2023 12:08 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	449,404	256,533	192,871	1,273	151.51	30.00
200.00	Total (lines 30 through 199)	449,404		192,871	1,273		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2	303				30.00
200.00	Total (lines 30 through 199)	2	303				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 11/27/2023 12:08 pm

Title XIX | Hospital | PPS

		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	125,306	2,131,117	0.058798	0	0	50.00
53.00	05300	ANESTHESIOLOGY	474	686,141	0.000691	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	68,745	13,245,714	0.005190	0	0	54.00
60.00	06000	LABORATORY	85,003	11,522,818	0.007377	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	64,412	2,684,660	0.023993	0	0	65.00
66.00	06600	PHYSICAL THERAPY	90,254	2,841,571	0.031762	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,938	889,515	0.021290	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,441	206,530	0.026345	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,136	911,829	0.003439	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,380	2,980,301	0.002812	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	53,923	5,543,536	0.009727	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	16,546	282,055	0.058662	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	44,916	4,594,527	0.009776	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	15,433	571,111	0.027023	0	0	88.01
90.00	09000	CLINIC	109,453	406,631	0.269170	0	0	90.00
90.01	09001	EAST MEDICAL CLINIC	475	1	475.000000	0	0	90.01
91.00	09100	EMERGENCY	111,135	4,211,121	0.026391	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	68,786	4,768,588	0.014425	0	0	92.00
200.00		Total (lines 50 through 199)	890,756	58,477,766		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part III Date/Time Prepared: 11/27/2023 12:08 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,273	0.00	2	30.00
200.00		Total (lines 30 through 199)		0	1,273		2	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/27/2023 12:08 pm

Title XIX | Hospital | PPS

		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	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	520,215	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	0	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	EAST MEDICAL CLINIC	0	0	0	0	0	90.01
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)	520,215	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/27/2023 12:08 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	2,131,117	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	520,215	0	686,141	0.758175	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,245,714	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	11,522,818	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,684,660	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,841,571	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	889,515	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	206,530	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	911,829	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,980,301	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,543,536	0.000000	73.00
73.01	07301	CARDIAC REHABILITATION	0	0	0	282,055	0.000000	73.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,594,527	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0	0	0	571,111	0.000000	88.01
90.00	09000	CLINIC	0	0	0	406,631	0.000000	90.00
90.01	09001	EAST MEDICAL CLINIC	0	0	0	1	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	4,211,121	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,768,588	0.000000	92.00
200.00		Total (lines 50 through 199)	0	520,215	0	58,477,766		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/27/2023 12:08 pm

Title XIX | Hospital | PPS

		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
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0.000000	0	0	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	EAST MEDICAL CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/27/2023 12:08 pm

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,192	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,273	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)	819	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	880	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)	788	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	125	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)	126	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	576	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)	680	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)	647	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	195.99	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	209.71	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,999,289	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)	24,499	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)	26,423	25.00
26.00	Total swing-bed cost (see instructions)	3,424,569	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,574,720	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,574,720	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,022.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,165,000	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,165,000	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/27/2023 12:08 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	620,149	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)	1,785,149	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)	1,375,348	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,308,603	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	2,683,951	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)	454	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,022.56	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1331	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/27/2023 12:08 pm
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	918,242	89.00

	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	449,404	5,999,289	0.074910	918,242	68,786	90.00
91.00	Nursing Program cost	0	5,999,289	0.000000	918,242	0	91.00
92.00	Allied health cost	0	5,999,289	0.000000	918,242	0	92.00
93.00	All other Medical Education	0	5,999,289	0.000000	918,242	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/27/2023 12:08 pm

Title XIX | Hospital | PPS

	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)	3,192	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,273	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)	819	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	880	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)	788	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	125	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)	126	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2	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)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	195.99	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	209.71	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,999,289	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)	24,499	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)	26,423	25.00
26.00	Total swing-bed cost (see instructions)	3,424,569	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,574,720	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,574,720	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,022.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,045	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)	4,045	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/27/2023 12:08 pm

Title XIX | Hospital | PPS

	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)	0	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)	4,045	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)	303	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)	303	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,742	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)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	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)	454	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,022.56	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1331	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/27/2023 12:08 pm
	Title XIX	Hospital	PPS

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	918,242	89.00

	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	449,404	5,999,289	0.074910	918,242	68,786	90.00
91.00	Nursing Program cost	0	5,999,289	0.000000	918,242	0	91.00
92.00	Allied health cost	0	5,999,289	0.000000	918,242	0	92.00
93.00	All other Medical Education	0	5,999,289	0.000000	918,242	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/27/2023 12:08 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		646,944		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.595304	118,172	70,348	50.00
53.00	05300	ANESTHESIOLOGY	0.771615	11,478	8,857	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190799	261,910	49,972	54.00
60.00	06000	LABORATORY	0.234945	414,674	97,426	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.378415	320,749	121,376	65.00
66.00	06600	PHYSICAL THERAPY	0.597963	35,709	21,353	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.515069	18,404	9,479	67.00
68.00	06800	SPEECH PATHOLOGY	0.971651	2,292	2,227	68.00
69.00	06900	ELECTROCARDIOLOGY	0.104850	12,493	1,310	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.201483	364,934	73,528	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.441002	333,182	146,934	73.00
73.01	07301	CARDIAC REHABILITATION	0.949545	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0.000000		0	88.01
90.00	09000	CLINIC	2.754003	0	0	90.00
90.01	09001	EAST MEDICAL CLINIC	42,143.000000	0	0	90.01
91.00	09100	EMERGENCY	0.928376	4,868	4,519	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.192561	66,576	12,820	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,965,441	620,149	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,965,441		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3

Component CCN: 14-Z331 | Date/Time Prepared: 11/27/2023 12:08 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.595304	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.771615	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190799	75,960	14,493	54.00
60.00	06000	LABORATORY	0.234945	424,284	99,683	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.378415	702,415	265,804	65.00
66.00	06600	PHYSICAL THERAPY	0.597963	228,347	136,543	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.515069	224,634	115,702	67.00
68.00	06800	SPEECH PATHOLOGY	0.971651	4,068	3,953	68.00
69.00	06900	ELECTROCARDIOLOGY	0.104850	10,732	1,125	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.201483	304,583	61,368	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.441002	583,998	257,544	73.00
73.01	07301	CARDIAC REHABILITATION	0.949545	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	0.000000		0	88.01
90.00	09000	CLINIC	2.754003	0	0	90.00
90.01	09001	EAST MEDICAL CLINIC	42,143.000000	0	0	90.01
91.00	09100	EMERGENCY	0.928376	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.192561	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,559,021	956,215	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)		2,559,021		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/27/2023 12:08 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.595304	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.771615	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190799	0	0	54.00
60.00	06000	LABORATORY	0.234945	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.378415	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.597963	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.515069	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.971651	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.104850	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.201483	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.441002	0	0	73.00
73.01	07301	CARDIAC REHABILITATION	0.949545	0	0	73.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.756684	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHC	2.147500	0	0	88.01
90.00	09000	CLINIC	2.754003	0	0	90.00
90.01	09001	EAST MEDICAL CLINIC	42,143.000000	0	0	90.01
91.00	09100	EMERGENCY	0.928376	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.192561	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1331	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/27/2023 12:08 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,883,197	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)	5,883,197	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)	5,942,029	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)	59,840	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,474,026	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)	3,408,163	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)	3,408,163	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	3,408,163	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)	372,715	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	242,265	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	372,715	36.00
37.00	Subtotal (see instructions)	3,650,428	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)	3,650,428	40.00
40.01	Sequestration adjustment (see instructions)	73,009	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	3,609,026	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)	-31,607	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: 14-1331	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/27/2023 12:08 pm
	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: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I Date/Time Prepared: 11/27/2023 12:08 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,480,084		3,609,026	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)		1,480,084		3,609,026	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		93,038		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		31,607	6.02
7.00	Total Medicare program liability (see instructions)		1,573,122		3,577,419	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES	05901		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1331 | Component CCN: 14-Z331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/27/2023 12:08 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,328,114		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)		3,328,114		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		248,689		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,576,803		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES	05901		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1331	Period: From 07/01/2022 To 06/30/2023	Worksheet E-1 Part II Date/Time Prepared: 11/27/2023 12:08 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (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: 14-1331 | Component CCN: 14-Z331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-2 | Date/Time Prepared: 11/27/2023 12:08 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	2,710,791	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)	965,777	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	1,327	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	3,676,568	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	3,676,568	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	3,676,568	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	26,769	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	3,649,799	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	3,649,799	0	19.00
19.01	Sequestration adjustment (see instructions)	72,996	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	3,328,114	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)	248,689	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: 14-1331	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part V Date/Time Prepared: 11/27/2023 12:08 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,785,149	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)	1,785,149	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,803,000	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,803,000	19.00
20.00	Deductibles (exclude professional component)	198,344	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,604,656	22.00
23.00	Coinsurance	3,710	23.00
24.00	Subtotal (line 22 minus line 23)	1,600,946	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	6,586	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	4,281	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	6,586	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,605,227	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)	1,605,227	30.00
30.01	Sequestration adjustment (see instructions)	32,105	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,480,084	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)	93,038	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1331	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 11/27/2023 12:08 pm
	Title XIX	Hospital	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 14-1331

Period: From 07/01/2022 To 06/30/2023

Worksheet G

Date/Time Prepared: 11/27/2023 12:08 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,223,469	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	6,593,331	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-522,736	0	0	0	6.00
7.00	Inventory	641,218	0	0	0	7.00
8.00	Prepaid expenses	1,512,195	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,447,477	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,114	0	0	0	12.00
13.00	Land improvements	1,285,234	0	0	0	13.00
14.00	Accumulated depreciation	-1,191,573	0	0	0	14.00
15.00	Buildings	8,239,442	0	0	0	15.00
16.00	Accumulated depreciation	-5,790,747	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	7,064,024	0	0	0	19.00
20.00	Accumulated depreciation	-6,065,804	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	6,413,881	0	0	0	23.00
24.00	Accumulated depreciation	-5,055,718	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	1,586,972	0	0	0	27.00
28.00	Accumulated depreciation	-1,586,972	0	0	0	28.00
29.00	Minor equipment-nondepreciable	2,329,548	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,231,401	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	8,270,808	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	222,251	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,493,059	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	26,171,937	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,102,085	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,470,184	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	355,983	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	0	0	0	0	43.00
44.00	Other current liabilities	33,427	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,961,679	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,284,514	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	699,396	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,983,910	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,945,589	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	12,226,348				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)	12,226,348	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	26,171,937	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-1 | Date/Time Prepared: 11/27/2023 12:08 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		12,050,669		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		175,680				2.00
3.00	Total (sum of line 1 and line 2)		12,226,349		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)		12,226,349		0		11.00
12.00	ROUNDING	1		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)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,226,348		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	ROUNDING		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: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/27/2023 12:08 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,241,554		1,241,554	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	853,801		853,801	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,095,355		2,095,355	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)	2,095,355		2,095,355	17.00
18.00	Ancillary services	6,142,645	39,027,165	45,169,810	18.00
19.00	Outpatient services	0	9,436,883	9,436,883	19.00
20.00	RURAL HEALTH CLINIC	0	4,594,527	4,594,527	20.00
20.01	RURAL HEALTH CLINIC II - FHC	0	571,111	571,111	20.01
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	OTHER PATIENT REVENUES	0	925,956	925,956	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,238,000	54,555,642	62,793,642	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		32,865,658		29.00
30.00	BAD DEBT EXPENSE	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)		32,865,658		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-3 | Date/Time Prepared: 11/27/2023 12:08 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	62,793,642	1.00
2.00	Less contractual allowances and discounts on patients' accounts	32,184,235	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,609,407	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32,865,658	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,256,251	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	107,150	6.00
7.00	Income from investments	601,518	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	10,286	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	59,555	14.00
15.00	Revenue from rental of living quarters	204,166	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	35,456	17.00
18.00	Revenue from sale of medical records and abstracts	5,410	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	7,050	22.00
23.00	Governmental appropriations	0	23.00
24.00	340B PROGRAM (NET OF EXPENSES)	349,162	24.00
24.01	OTHER INCOME	162,996	24.01
24.02	LOSS ON EXTINGUISHMENT OF DEBT	-231,959	24.02
24.03	OTHER (SPECIFY)	0	24.03
24.04	OTHER (SPECIFY)	0	24.04
24.05	OTHER (SPECIFY)	0	24.05
24.06	OTHER (SPECIFY)	0	24.06
24.07	OTHER (SPECIFY)	0	24.07
24.50	COVID-19 PHE Funding	1,122,602	24.50
25.00	Total other income (sum of lines 6-24)	2,433,392	25.00
26.00	Total (line 5 plus line 25)	177,141	26.00
27.00	LOSS ON SALE OF EQUIPMENT	1,461	27.00
27.01	OTHER EXPENSES (SPECIFY)	0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	1,461	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	175,680	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1331 | Component CCN: 14-8504 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/27/2023 12:08 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	413,952	401,543	815,495	59,498	874,993	1.00
2.00	Physician Assistant	263,425	0	263,425	25,984	289,409	2.00
3.00	Nurse Practitioner	413,092	0	413,092	45,152	458,244	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	314,627	0	314,627	17,832	332,459	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,405,096	401,543	1,806,639	148,466	1,955,105	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	87,081	87,081	1,931	89,012	15.00
16.00	Transportation (Health Care Staff)	0	7,956	7,956	0	7,956	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	95,037	95,037	1,931	96,968	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,405,096	496,580	1,901,676	150,397	2,052,073	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	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	10,838	10,838	86,649	97,487	29.00
30.00	Administrative Costs	211,278	32,285	243,563	0	243,563	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	211,278	43,123	254,401	86,649	341,050	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,616,374	539,703	2,156,077	237,046	2,393,123	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1331 | Component CCN: 14-8504 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/27/2023 12:08 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-304	874,689		1.00
2.00	Physician Assistant	-100	289,309		2.00
3.00	Nurse Practitioner	-159	458,085		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	332,459		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-563	1,954,542		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	89,012		15.00
16.00	Transportation (Health Care Staff)	0	7,956		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	96,968		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-563	2,051,510		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	563	563		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	563	563		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	97,487		29.00
30.00	Administrative Costs	0	243,563		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	341,050		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,393,123		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1331 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1

Component CCN: 14-8597 | Date/Time Prepared: 11/27/2023 12:08 pm

RHC II | 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	0	40,000	40,000	0	40,000	1.00
2.00	Physician Assistant	141,421	0	141,421	13,763	155,184	2.00
3.00	Nurse Practitioner	142,819	0	142,819	15,933	158,752	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	205,919	0	205,919	0	205,919	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	490,159	40,000	530,159	29,696	559,855	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	23,622	23,622	0	23,622	15.00
16.00	Transportation (Health Care Staff)	0	1,668	1,668	0	1,668	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	25,290	25,290	0	25,290	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	490,159	65,290	555,449	29,696	585,145	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	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	12,798	12,798	41,702	54,500	29.00
30.00	Administrative Costs	136,797	10,190	146,987	0	146,987	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	136,797	22,988	159,785	41,702	201,487	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	626,956	88,278	715,234	71,398	786,632	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1331 | Component CCN: 14-8597 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/27/2023 12:08 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-337	39,663		1.00
2.00	Physician Assistant	-1,307	153,877		2.00
3.00	Nurse Practitioner	-1,337	157,415		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	205,919		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-2,981	556,874		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	23,622		15.00
16.00	Transportation (Health Care Staff)	0	1,668		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	25,290		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-2,981	582,164		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	2,981	2,981		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	2,981	2,981		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	54,500		29.00
30.00	Administrative Costs	0	146,987		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	201,487		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	786,632		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1331
Component CCN: 14-8504

Period: From 07/01/2022 To 06/30/2023

Worksheet M-2

Date/Time Prepared: 11/27/2023 12:08 pm

RHC I

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.95	4,266	4,200	8,190		1.00
2.00	Physician Assistant	1.23	3,577	2,100	2,583		2.00
3.00	Nurse Practitioner	2.40	6,550	2,100	5,040		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.58	14,393		15,813	15,813	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.58	14,393			15,813	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)					2,051,510	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					563	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,052,073	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999726	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					341,050	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,083,482	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,424,532	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,424,532	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,424,142	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,475,652	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1331
Component CCN: 14-8597

Period: From 07/01/2022 To 06/30/2023

Worksheet M-2

Date/Time Prepared: 11/27/2023 12:08 pm

RHC II

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	421	4,200	0		1.00
2.00	Physician Assistant	0.66	1,590	2,100	1,386		2.00
3.00	Nurse Practitioner	0.73	1,404	2,100	1,533		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.39	3,415		2,919	3,415	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.39	3,415			3,415	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)					582,164	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					2,981	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					585,145	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.994906	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					201,487	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					439,829	15.00
16.00	Total overhead (sum of lines 14 and 15)					641,316	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					641,316	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					638,049	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,220,213	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1331 Component CCN: 14-8504	Period: From 07/01/2022 To 06/30/2023	Worksheet M-3 Date/Time Prepared: 11/27/2023 12:08 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		3,475,652	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		44,495	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		3,431,157	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		15,813	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)		15,813	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		216.98	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)	264.93	275.00	8.00
9.00	Rate for Program covered visits (see instructions)	216.98	216.98	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,834	1,923	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	397,941	417,253	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	815,194	16.00
16.01	Total program charges (see instructions)(from contractor's records)		623,879	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		13,644	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		17,828	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.)		588,848	16.04
16.05	Total program cost (see instructions)	0	606,676	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		61,306	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		109,650	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		606,676	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		34,173	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		640,849	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)		640,849	26.00
26.01	Sequestration adjustment (see instructions)		12,817	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		749,976	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)		-121,944	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1331 Component CCN: 14-8597	Period: From 07/01/2022 To 06/30/2023	Worksheet M-3 Date/Time Prepared: 11/27/2023 12:08 pm
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,220,213	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		6,911	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,213,302	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,415	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		3,415	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		355.29	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)	260.39	270.28	8.00
9.00	Rate for Program covered visits (see instructions)	260.39	270.28	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	432	447	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	112,488	120,815	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	233,303	16.00
16.01	Total program charges (see instructions)(from contractor's records)		168,602	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		10,101	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		13,977	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.)		162,222	16.04
16.05	Total program cost (see instructions)	0	176,199	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		16,549	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		28,390	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		176,199	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,206	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		181,405	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)		181,405	26.00
26.01	Sequestration adjustment (see instructions)		3,628	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		171,758	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)		6,019	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: 14-1331 Component CCN: 14-8504 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-4 Date/Time Prepared: 11/27/2023 12:08 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,954,542	1,954,542	1,954,542	1,954,542	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000516	0.000574	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,009	1,122	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	18,732	5,400	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	19,741	6,522	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,051,510	2,051,510	2,051,510	2,051,510	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,424,142	1,424,142	1,424,142	1,424,142	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.009623	0.003179	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	13,705	4,527	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	33,446	11,049	0	0	10.00
11.00	Total number of injections/infusions (from your records)	80	89	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	418.08	124.15	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	66	53	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)	27,593	6,580	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)		44,495	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)		34,173	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1331 Component CCN: 14-8597 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-4 Date/Time Prepared: 11/27/2023 12:08 pm

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	556,874	556,874	556,874	556,874	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000085	0.000160	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	47	89	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	2,130	1,031	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,177	1,120	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	582,164	582,164	582,164	582,164	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	638,049	638,049	638,049	638,049	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.003739	0.001924	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2,386	1,228	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	4,563	2,348	0	0	10.00
11.00	Total number of injections/infusions (from your records)	9	17	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	507.00	138.12	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	7	12	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	3,549	1,657	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)		6,911	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)		5,206	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1331 Component CCN: 14-8504	Period: From 07/01/2022 To 06/30/2023	Worksheet M-5 Date/Time Prepared: 11/27/2023 12:08 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		749,976	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)		749,976	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		121,944	6.02
7.00	Total Medicare program liability (see instructions)		628,032	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES	05901		8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-1331
Component CCN: 14-8597

Period:
From 07/01/2022
To 06/30/2023

Worksheet M-5

Date/Time Prepared:
11/27/2023 12:08 pm

RHC II

Cost

		Part B mm/dd/yyyy 1.00	Part B Amount 2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		171,758	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)		171,758	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		6,019	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		177,777	7.00

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