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: 14-1325	Period: From 10/01/2022 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/24/2024 6:39 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/24/2024 Time: 6:39 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 OSF SAINT LUKE MEDICAL CENTER (14-1325) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 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				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title				3
4	Date				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	40,694	-304,301	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	-18,710	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		96,879		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	TOTAL	0	21,984	-207,422	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: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/24/2024 6:39 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1051 WEST SOUTH STREET	PO Box: 747			1.00
2.00	City: KEWANEE	State: IL	Zip Code: 61443	County: HENRY	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	OSF SAINT LUKE MEDICAL CENTER	141325	19340	1	07/01/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	OSF SAINT LUKE SWING BED	14Z325	19340		03/19/2003	N	O	N	7.00
8.00	Swing Beds - NF	OSF SAINT LUKE SWING BED	14Z325	19340		03/19/2003	N		N	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	FAMILY HEALTH CLINIC	143445	19340		10/01/1998	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2022	09/30/2023	20.00
21.00	Type of Control (see instructions)	1		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/24/2024 6:39 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.				57.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2024 6:39 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.				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: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2024 6:39 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: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2024 6:39 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)?				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.	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2024 6:39 pm

		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.	N	N	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/24/2024 6:39 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,396,204	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	Y	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB1728	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: OSF HEALTHCARE SYSTEM	Contractor's Name: WPS	Contractor's Number: 05901	141.00
142.00	Street: 124 SW ADAMS	PO Box:		142.00
143.00	City: PEORIA	State: IL	Zip Code: 61602	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: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2024 6:39 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.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.00	169.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/24/2024 6:39 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)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	Y	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	12/13/2023	Y	12/13/2023	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: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II Date/Time Prepared: 2/24/2024 6:39 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	Y	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y	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.	Y	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA	RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	FORIVS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544	PATTY.RACHELL@FORVIS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1325	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part II Date/Time Prepared: 2/24/2024 6:39 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.	MANAGING DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 2/24/2024 6:39 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	22	8,030	20,311.20	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		22	8,030	20,311.20	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	3	1,095	396.44	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	20,707.64	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	RHC (CONSOLIDATED)	88.00				0	26.00
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: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/24/2024 6:39 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)	388	9	833			1.00
2.00	HMO and other (see instructions)	287	69				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	246	0	454			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	43			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	634	9	1,330			7.00
8.00	INTENSIVE CARE UNIT	12	0	16			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)	646	9	1,346	0.00	126.07	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	RHC (CONSOLIDATED)	6,083	11,196	35,311	0.00	54.63	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	180.70	27.00
28.00	Observation Bed Days		72	425			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: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/24/2024 6:39 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	149	6	394	1.00
2.00	HMO and other (see instructions)			99	47		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	149	6	394	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	RHC (CONSOLIDATED)	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1325 | Component CCN: 14-3445 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/24/2024 6:39 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1051 WEST SOUTH STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	KEWANEE		IL	61443	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:15	17:00	07:15	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.	Y	3		13.00

		Provider name	CCN	
		1.00	2.00	
14.00	RHC/FQHC name, CCN	KEWANEE CLINIC	143445	14.00
14.01		OSF MEDICAL GROUP SHEFFIELD	148594	14.01
14.02		OSF MEDICAL GROUP GALVA	148595	14.02

		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		HENRY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	07:15	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1325
Component CCN: 14-3445

Period:
From 10/01/2022
To 09/30/2023

Worksheet S-8

Date/Time Prepared:
2/24/2024 6:39 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	07:15	17:00	08:00	12:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1325	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/24/2024 6:39 pm

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.345270	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,842,187	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	24,039,285	6.00
7.00	Medicaid cost (line 1 times line 6)	8,300,044	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	3,457,857	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 (see instructions)	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 (see instructions)	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)	3,457,857	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	1,366,433	376,319	1,742,752	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	471,788	376,319	848,107	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 (see instructions)	471,788	376,319	848,107	23.00

		1.00	
24.00	Does the amount on line 20 col. 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
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	1,713,978	26.00
27.00	Medicare reimbursable bad debts (see instructions)	230,599	27.00
27.01	Medicare allowable bad debts (see instructions)	354,768	27.01
28.00	Non-Medicare bad debt amount (see instructions)	1,359,210	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	593,463	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,441,570	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,899,427	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 2/24/2024 6:39 pm

				1.00	
	PART II - HOSPITAL DATA				
	Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)				1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid				2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid				5.00
6.00	Medicaid charges				6.00
7.00	Medicaid cost (line 1 times line 6)				7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)				8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP				9.00
10.00	Stand-alone CHIP charges				10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)				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)				13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)				14.00
15.00	State or local indigent care program cost (line 1 times line 14)				15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)				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				17.00
18.00	Government grants, appropriations or transfers for support of hospital operations				18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)				19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)				20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)				21.00
22.00	Payments received from patients for amounts previously written off as charity care				22.00
23.00	Cost of charity care (see instructions)				23.00
				1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				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				25.00
25.01	Charges for insured patients' liability (see instructions)				25.01
26.00	Bad debt amount (see instructions)				26.00
27.00	Medicare reimbursable bad debts (see instructions)				27.00
27.01	Medicare allowable bad debts (see instructions)				27.01
28.00	Non-Medicare bad debt amount (see instructions)				28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)				29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)				30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/24/2024 6:39 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		636,848	636,848	40,083	676,931	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		596,218	596,218	0	596,218	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	194,412	1,526,049	1,720,461	2,330,348	4,050,809	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	954,292	8,051,400	9,005,692	415,650	9,421,342	5.00
7.00	00700	OPERATION OF PLANT	285,664	1,715,722	2,001,386	-463,003	1,538,383	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,620	78,415	89,035	7,872	96,907	8.00
9.00	00900	HOUSEKEEPING	425,329	202,453	627,782	-103,504	524,278	9.00
10.00	01000	DIETARY	298,721	279,298	578,019	-419,005	159,014	10.00
11.00	01100	CAFETERIA	0	0	0	333,950	333,950	11.00
13.00	01300	NURSING ADMINISTRATION	196,681	48,199	244,880	-41,951	202,929	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	129,649	111,019	240,668	-48,291	192,377	14.00
15.00	01500	PHARMACY	238,155	1,139,574	1,377,729	-29,302	1,348,427	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	56,550	56,550	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	348,592	348,592	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,415,966	1,074,010	2,489,976	-378,308	2,111,668	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	33,658	33,658	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	535,957	402,044	938,001	-133,286	804,715	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	62,760	-34,455	28,305	-5,823	22,482	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	465,406	132,212	597,618	336,677	934,295	54.00
54.01	03440	MAMMOGRAPHY	104,177	32,666	136,843	-21,441	115,402	54.01
56.00	05600	RADIOISOTOPE	0	204,831	204,831	841	205,672	56.00
56.01	03630	ULTRA SOUND	223,567	60,352	283,919	-49,313	234,606	56.01
57.00	05700	CT SCAN	208,813	130,170	338,983	-55,108	283,875	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	155,526	63,200	218,726	-34,731	183,995	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	899,250	1,196,252	2,095,502	-168,588	1,926,914	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	69,298	69,298	3,477	72,775	62.00
65.00	06500	RESPIRATORY THERAPY	275,113	130,158	405,271	-67,793	337,478	65.00
66.00	06600	PHYSICAL THERAPY	701,130	224,763	925,893	-174,343	751,550	66.00
67.00	06700	OCCUPATIONAL THERAPY	127,759	34,392	162,151	-24,221	137,930	67.00
68.00	06800	SPEECH PATHOLOGY	45,320	13,465	58,785	-8,395	50,390	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	247,097	70,022	317,119	-57,235	259,884	69.01
69.02	03650	VASCULAR LAB	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,828	31,828	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	422,687	422,687	0	422,687	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,131,939	3,007,709	8,139,648	-1,208,947	6,930,701	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,790,522	2,052,031	3,842,553	-341,960	3,500,593	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,123,825	23,671,002	38,794,827	104,978	38,899,805	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	70,762	47,924	118,686	-30,873	87,813	190.00
190.01	19001	FOUNDATION	0	144,470	144,470	-73,640	70,830	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,132	6,132	0	6,132	192.00
194.00	07950	INDUSTRIAL MEDICINE	817	283	1,100	-465	635	194.00
194.01	07951	RESEARCH	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	15,195,404	23,869,811	39,065,215	0	39,065,215	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/24/2024 6:39 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	721,388	1,398,319		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	339,881	936,099		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-37,418	4,013,391		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-766,559	8,654,783		5.00
7.00	00700	OPERATION OF PLANT	-14,528	1,523,855		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	96,907		8.00
9.00	00900	HOUSEKEEPING	0	524,278		9.00
10.00	01000	DIETARY	0	159,014		10.00
11.00	01100	CAFETERIA	-127,816	206,134		11.00
13.00	01300	NURSING ADMINISTRATION	372,921	575,850		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	192,377		14.00
15.00	01500	PHARMACY	-142	1,348,285		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-60	56,490		16.00
17.00	01700	SOCIAL SERVICE	-90,879	257,713		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-514,028	1,597,640		30.00
31.00	03100	INTENSIVE CARE UNIT	0	33,658		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-70,716	733,999		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	-18,066	4,416		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-20,831	913,464		54.00
54.01	03440	MAMMOGRAPHY	1,166	116,568		54.01
56.00	05600	RADIOISOTOPE	0	205,672		56.00
56.01	03630	ULTRA SOUND	0	234,606		56.01
57.00	05700	CT SCAN	0	283,875		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	183,995		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	-58,836	1,868,078		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	72,775		62.00
65.00	06500	RESPIRATORY THERAPY	-189	337,289		65.00
66.00	06600	PHYSICAL THERAPY	-86,519	665,031		66.00
67.00	06700	OCCUPATIONAL THERAPY	259	138,189		67.00
68.00	06800	SPEECH PATHOLOGY	94	50,484		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	259,884		69.01
69.02	03650	VASCULAR LAB	0	0		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	31,828		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-421,074	1,613		73.00
73.01	03480	ONCOLOGY	0	0		73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-382,402	6,548,299		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	-740,283	2,760,310		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,914,637	36,985,168		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	87,813		190.00
190.01	19001	FOUNDATION	0	70,830		190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,132		192.00
194.00	07950	INDUSTRIAL MEDICINE	0	635		194.00
194.01	07951	RESEARCH	0	0		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,914,637	37,150,578		200.00

RECLASSIFICATIONS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/24/2024 6:39 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - LAUNDRY EXPENSES					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	9,042		1.00
	0		0	9,042		
	B - CLINICAL ENGINEERING					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	451,264		1.00
2.00	LABORATORY	60.00	0	86,927		2.00
	0		0	538,191		
	C - CAFETERIA					
1.00	CAFETERIA	11.00	204,312	129,638		1.00
	0		204,312	129,638		
	D - BLOOD COSTS					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	1,810	1,667		1.00
	0		1,810	1,667		
	E - RHC REGIONAL ADMIN EXPENSE					
1.00	RURAL HEALTH CLINIC	88.00	0	17,209		1.00
	TOTALS		0	17,209		
	F - RADIOLOGY SERVICES					
1.00	MAMMOGRAPHY	54.01	0	841		1.00
2.00	RADIOISOTOPE	56.00	0	841		2.00
3.00	ULTRA SOUND	56.01	0	841		3.00
4.00	CT SCAN	57.00	0	841		4.00
5.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	841		5.00
	0		0	4,205		
	H - MINISTRY ALLOCATIONS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	187,973		1.00
2.00	OPERATION OF PLANT	7.00	0	104,233		2.00
3.00	PHARMACY	15.00	0	45,157		3.00
4.00	SOCIAL SERVICE	17.00	0	348,592		4.00
5.00	PHYSICAL THERAPY	66.00	0	22,787		5.00
6.00	OCCUPATIONAL THERAPY	67.00	0	3,991		6.00
7.00	SPEECH PATHOLOGY	68.00	0	1,447		7.00
	0		0	714,180		
	I - OTHER THERAPUTIC SERVICES					
1.00	OPERATING ROOM	50.00	10,777	0		1.00
	0		10,777	0		
	J - SURGEON RHC					
1.00	OPERATING ROOM	50.00	70,103	3,458		1.00
	0		70,103	3,458		
	K - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	31,828		1.00
	0		0	31,828		
	L - ICU COSTS					
1.00	INTENSIVE CARE UNIT	31.00	32,014	1,644		1.00
	0		32,014	1,644		
	Q - RHC SHARED BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,052,007		1.00
	0		0	1,052,007		
	R - REPAIRS AND MAINTENANCE					
1.00	OPERATION OF PLANT	7.00	0	32,686		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	0		0	32,686		
	S - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	40,083		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,325,376		2.00
	0		0	1,365,459		
	T - BENEFITS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,728,891		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00

RECLASSIFICATIONS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/24/2024 6:39 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
	0		0	2,728,891		
	U - VACATIONS, PTO, REWARDS					
1.00	ADMINISTRATIVE & GENERAL	5.00	5,737	0		1.00
2.00	OPERATION OF PLANT	7.00	1,498	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	56	0		3.00
4.00	HOUSEKEEPING	9.00	2,278	0		4.00
5.00	DIETARY	10.00	1,566	0		5.00
6.00	NURSING ADMINISTRATION	13.00	1,031	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	680	0		7.00
8.00	PHARMACY	15.00	1,249	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	7,424	0		9.00
10.00	OPERATING ROOM	50.00	2,810	0		10.00
11.00	ANESTHESIOLOGY	53.00	329	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	2,440	0		12.00
13.00	MAMMOGRAPHY	54.01	546	0		13.00
14.00	ULTRA SOUND	56.01	1,172	0		14.00
15.00	CT SCAN	57.00	1,095	0		15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	815	0		16.00
17.00	LABORATORY	60.00	4,715	0		17.00
18.00	RESPIRATORY THERAPY	65.00	1,442	0		18.00
19.00	PHYSICAL THERAPY	66.00	3,676	0		19.00
20.00	OCCUPATIONAL THERAPY	67.00	670	0		20.00
21.00	SPEECH PATHOLOGY	68.00	238	0		21.00
22.00	CARDIOPULMONARY	69.01	1,296	0		22.00
23.00	RURAL HEALTH CLINIC	88.00	26,907	0		23.00
24.00	EMERGENCY	91.00	9,388	0		24.00
25.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	371	0		25.00
26.00	INDUSTRIAL MEDICINE	194.00	4	0		26.00
	0		79,433	0		
	V - RETENTION BONUS					
1.00	ADMINISTRATIVE & GENERAL	5.00	10,014	0		1.00
2.00	OPERATION OF PLANT	7.00	2,999	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	111	0		3.00
4.00	HOUSEKEEPING	9.00	4,465	0		4.00
5.00	DIETARY	10.00	3,136	0		5.00
6.00	NURSING ADMINISTRATION	13.00	2,065	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	1,361	0		7.00
8.00	PHARMACY	15.00	2,500	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	33,508	0		9.00
10.00	OPERATING ROOM	50.00	12,797	0		10.00
11.00	ANESTHESIOLOGY	53.00	659	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	4,885	0		12.00
13.00	MAMMOGRAPHY	54.01	1,094	0		13.00
14.00	ULTRA SOUND	56.01	2,347	0		14.00
15.00	CT SCAN	57.00	2,192	0		15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	1,633	0		16.00
17.00	LABORATORY	60.00	9,440	0		17.00
18.00	RESPIRATORY THERAPY	65.00	6,330	0		18.00
19.00	PHYSICAL THERAPY	66.00	7,360	0		19.00
20.00	OCCUPATIONAL THERAPY	67.00	1,341	0		20.00
21.00	SPEECH PATHOLOGY	68.00	476	0		21.00
22.00	CARDIOPULMONARY	69.01	3,110	0		22.00
23.00	RURAL HEALTH CLINIC	88.00	53,871	0		23.00
24.00	EMERGENCY	91.00	25,966	0		24.00

RECLASSIFICATIONS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/24/2024 6:39 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
25.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	743	0		25.00
26.00	INDUSTRIAL MEDICINE	194.00	9	0		26.00
	TOTALS		194,412	0		
	W - SHORT TERM DISABILITY					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	881		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	2,374		2.00
	TOTALS		0	3,255		
	X - MINISTRY MEDICAL RECORDS					
1.00	MEDICAL RECORDS & LIBRARY	16.00	0	56,550		1.00
	0		0	56,550		
	Y - FOUNDATION EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	70,140		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	3,500		2.00
	0		0	73,640		
	Z - RHC PULMONARY PHY					
1.00	RESPIRATORY THERAPY	65.00	189	0		1.00
	0		189	0		
500.00	Grand Total: Increases		593,050	6,763,550		500.00

RECLASSIFICATIONS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/24/2024 6:39 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LAUNDRY EXPENSES						
1.00	HOUSEKEEPING	9.00	0	9,042	0		1.00
	0		0	9,042			
	B - CLINICAL ENGINEERING						
1.00	OPERATION OF PLANT	7.00	0	538,191	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	538,191			
	C - CAFETERIA						
1.00	DIETARY	10.00	204,312	129,638	0		1.00
	0		204,312	129,638			
	D - BLOOD COSTS						
1.00	LABORATORY	60.00	1,810	1,667	0		1.00
	0		1,810	1,667			
	E - RHC REGIONAL ADMIN EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,209	0		1.00
	TOTALS		0	17,209			
	F - RADIOLOGY SERVICES						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,205	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	0		0	4,205			
	H - MINISTRY ALLOCATIONS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	714,180	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	0		0	714,180			
	I - OTHER THERAPUTIC SERVICES						
1.00	ADULTS & PEDIATRICS	30.00	10,777	0	0		1.00
	0		10,777	0			
	J - SURGEON RHC						
1.00	RURAL HEALTH CLINIC	88.00	70,103	3,458	0		1.00
	0		70,103	3,458			
	K - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	31,828	0		1.00
	0		0	31,828			
	L - ICU COSTS						
1.00	ADULTS & PEDIATRICS	30.00	32,014	1,644	0		1.00
	0		32,014	1,644			
	Q - RHC SHARED BENEFITS						
1.00	RURAL HEALTH CLINIC	88.00	0	1,052,007	0		1.00
	0		0	1,052,007			
	R - REPAIRS AND MAINTENANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	319	0		1.00
2.00	HOUSEKEEPING	9.00	0	2,673	0		2.00
3.00	DIETARY	10.00	0	11,478	0		3.00
4.00	PHARMACY	15.00	0	2,217	0		4.00
5.00	LABORATORY	60.00	0	12,849	0		5.00
6.00	RURAL HEALTH CLINIC	88.00	0	750	0		6.00
7.00	EMERGENCY	91.00	0	2,400	0		7.00
	0		0	32,686			
	S - INSURANCE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,365,459	12		1.00
2.00		0.00	0	0	0		2.00
	0		0	1,365,459			
	T - BENEFITS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	206,626	0		1.00
2.00	OPERATION OF PLANT	7.00	0	66,228	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	1,337	0		3.00
4.00	HOUSEKEEPING	9.00	0	98,484	0		4.00
5.00	DIETARY	10.00	0	78,279	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	45,047	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	50,332	0		7.00
8.00	PHARMACY	15.00	0	75,991	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	374,805	0		9.00
10.00	OPERATING ROOM	50.00	0	201,403	0		10.00
11.00	ANESTHESIOLOGY	53.00	0	6,811	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	117,707	0		12.00
13.00	MAMMOGRAPHY	54.01	0	23,922	0		13.00

RECLASSIFICATIONS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/24/2024 6:39 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
14.00	ULTRA SOUND	56.01	0	53,673	0		14.00
15.00	CT SCAN	57.00	0	59,236	0		15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	38,020	0		16.00
17.00	LABORATORY	60.00	0	253,344	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	75,754	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	208,166	0		19.00
20.00	OCCUPATIONAL THERAPY	67.00	0	30,223	0		20.00
21.00	SPEECH PATHOLOGY	68.00	0	10,556	0		21.00
22.00	CARDIOPULMONARY	69.01	0	61,641	0		22.00
23.00	RURAL HEALTH CLINIC	88.00	0	183,927	0		23.00
24.00	EMERGENCY	91.00	0	374,914	0		24.00
25.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	31,987	0		25.00
26.00	INDUSTRIAL MEDICINE	194.00	0	478	0		26.00
	0		0	2,728,891			
	U - VACATIONS, PTO, REWARDS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	78,652	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	733	0		2.00
3.00	HOUSEKEEPING	9.00	0	48	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
	0		0	79,433			
	V - RETENTION BONUS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	194,412	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
	TOTALS		194,412	0			

RECLASSIFICATIONS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/24/2024 6:39 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	W - SHORT TERM DISABILITY						
1.00	ADMINISTRATIVE & GENERAL	5.00	881	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	2,374	0	0		2.00
	TOTALS		3,255	0			
	X - MINISTRY MEDICAL RECORDS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	56,550	0		1.00
	0		0	56,550			
	Y - FOUNDATION EXPENSE						
1.00	FOUNDATION	190.01	0	73,640	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	73,640			
	Z - RHC PULMONARY PHY						
1.00	RURAL HEALTH CLINIC	88.00	189	0	0		1.00
	0		189	0			
500.00	Grand Total: Decreases		516,872	6,839,728			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 2/24/2024 6:39 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	1,712,018	0	0	0	0	1.00
2.00	Land Improvements	1,390,342	0	0	0	0	2.00
3.00	Buildings and Fixtures	22,093,776	292,600	0	292,600	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	11,902,805	470,162	0	470,162	0	6.00
7.00	HIT designated Assets	4,714,976	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	41,813,917	762,762	0	762,762	0	8.00
9.00	Reconciling Items	102,510	232,368	0	232,368	0	9.00
10.00	Total (line 8 minus line 9)	41,711,407	530,394	0	530,394	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,712,018	0	1.00
2.00	Land Improvements	1,390,342	0	2.00
3.00	Buildings and Fixtures	22,386,376	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	12,372,967	0	6.00
7.00	HIT designated Assets	4,714,976	0	7.00
8.00	Subtotal (sum of lines 1-7)	42,576,679	0	8.00
9.00	Reconciling Items	334,878	0	9.00
10.00	Total (line 8 minus line 9)	42,241,801	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 2/24/2024 6:39 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	636,848	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	596,218	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,233,066	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	636,848		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	596,218		2.00
3.00	Total (sum of lines 1-2)	0	1,233,066		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 2/24/2024 6:39 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	25,488,736	0	25,488,736	0.598655	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17,087,943	0	17,087,943	0.401345	0	2.00
3.00	Total (sum of lines 1-2)	42,576,679	0	42,576,679	1.000000	0	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	0	1,358,236	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	936,099	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,294,335	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	0	40,083	0	0	1,398,319	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	936,099	2.00
3.00	Total (sum of lines 1-2)	0	40,083	0	0	2,334,418	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/24/2024 6:39 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)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	0	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,334,043			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	538,274			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-127,816	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-60	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	*** Cost Center Deleted ***	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: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/24/2024 6:39 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	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISC INC	B	-16	RURAL HEALTH CLINIC	88.00	0	33.00
33.01	MISC INC	B	-46,240	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISC INC	B	-26,955	PHYSICAL THERAPY	66.00	0	33.02
33.03	MISC INC	B	-142	PHARMACY	15.00	0	33.03
33.04	MISC INC	B	-2,746	RURAL HEALTH CLINIC	88.00	0	33.04
33.05	MISC INC	B	-31,825	LABORATORY	60.00	0	33.05
33.06	PROVIDER TAX	A	-1,165,330	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	CRNA - SALARY	A	-62,760	ANESTHESIOLOGY	53.00	0	33.07
33.08	CRNA - BENEFITS	A	-12,585	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	CRNA - OTHER EXPENSE	A	-25,849	ANESTHESIOLOGY	53.00	0	33.09
33.10	LOBBYING	A	-12,198	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	REAL ESTATE TAXES	A	-29,660	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	IMPAIRMENT OF ASSETS	A	413,833	CAP REL COSTS-BLDG & FIXT	1.00	9	33.12
33.13	IMPAIRMENT OF ASSETS	A	-38,200	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.13
33.14	NONALLOWABLE RHC COSTS	A	-1,363	RURAL HEALTH CLINIC	88.00	0	33.14
33.15	RE-LIFING OFFSET	A	490,551	CAP REL COSTS-BLDG & FIXT	1.00	9	33.15
33.16	RE-LIFING OFFSET	A	-10,260	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.16
33.17	340B OFFSET	A	-422,687	DRUGS CHARGED TO PATIENTS	73.00	0	33.17
33.18	SPORTSCARE SALARIES	A	-58,828	PHYSICAL THERAPY	66.00	0	33.18
33.19	SPORTSCARE EXPENSES	A	-2,214	PHYSICAL THERAPY	66.00	0	33.19
33.20	SPORTSCARE BENEFITS	A	-11,795	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	PHYSICIAN BENEFITS	A	-6,057	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.21
33.22	OTHER OPERATING REVENUE - FARM INCOM	B	-17,875	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	OSFMG CRNA EXPENSE	A	72,820	ANESTHESIOLOGY	53.00	0	33.23
33.24	OSFMG ED REVENUE	A	1,019,592	EMERGENCY	91.00	0	33.24
33.25	MEDICAL TRANSPORTATION SVCS SALARIES	A	-29,725	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	MEDICAL TRANSPORTATION SVCS EXPENSES	A	-6,090	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	MEDICAL TRANSPORTATION SVCS BENEFITS	A	-5,960	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.27
33.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.28
33.29	PHYSICIAN RECRUITMENT	A	-900	EMERGENCY	91.00	0	33.29
33.30	COMMUNITY HEALTH SVCS SALARIES	A	-5,093	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	COMMUNITY HEALTH SVCS EXPENSES	A	-14,234	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	COMMUNITY HEALTH SVCS BENEFITS	A	-1,021	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.32
33.33	GUILD ADJUSTMENT	A	2,845	OPERATING ROOM	50.00	0	33.33
33.34	GUILD ADJUSTMENT	A	2,845	EMERGENCY	91.00	0	33.34
33.35	ADVERTISING AND MARKETING	A	1,166	MAMMOGRAPHY	54.01	0	33.35
33.36	ADVERTISING AND MARKETING	A	-18	RURAL HEALTH CLINIC	88.00	0	33.36
33.37	PUBLIC RELATIONS	A	-4,925	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38	MALPRACTICE EXPENSE	A	58,907	ADMINISTRATIVE & GENERAL	5.00	0	33.38
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,914,637				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/24/2024 6:39 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL BLDG HO BLDG CAPITA	162,764	345,760	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	403,630	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HO POOLED - ADMIN & GENERAL	2,701,692	3,779,648	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	MINISTRY ALLOCATION	187,973	187,973	3.01
3.02	7.00	OPERATION OF PLANT	MINISTRY ALLOCATION	104,525	104,525	3.02
3.03	30.00	ADULTS & PEDIATRICS	MINISTRY ALLOCATION	26,712	0	3.03
3.04	66.00	PHYSICAL THERAPY	MINISTRY ALLOCATION	24,265	22,787	3.04
3.05	67.00	OCCUPATIONAL THERAPY	MINISTRY ALLOCATION	4,250	3,991	3.05
3.06	68.00	SPEECH PATHOLOGY	MINISTRY ALLOCATION	1,541	1,447	3.06
3.07	15.00	PHARMACY	MINISTRY ALLOCATION	45,157	45,157	3.07
3.08	54.00	RADIOLOGY-DIAGNOSTIC	MINISTRY ALLOCATION	419	419	3.08
3.09	60.00	LABORATORY	MINISTRY ALLOCATION	81	81	3.09
3.10	13.00	NURSING ADMINISTRATION	HO FUNCTIONAL - NURSING ADMI	372,921	0	3.10
3.11	13.00	NURSING ADMINISTRATION	HO FUNCTIONAL - NURSING ADMI	98,246	98,246	3.11
3.12	17.00	SOCIAL SERVICE	HO FUNCTIONAL - SOCIAL SERVI	257,713	348,592	3.12
3.13	5.00	ADMINISTRATIVE & GENERAL	HO FUNCTIONAL - ADMIN & GEN	3,334,134	1,749,719	3.13
3.14	73.00	DRUGS CHARGED TO PATIENTS	HO FUNCTIONAL - PHARMACY	1,613	0	3.14
3.15	54.00	RADIOLOGY-DIAGNOSTIC	SFI HTM EQUIPMENT RENTAL	456	464	3.15
3.16	5.00	ADMINISTRATIVE & GENERAL	SFI CVO	27,490	27,429	3.16
3.17	7.00	OPERATION OF PLANT	SFI HEALTHCARE TECHNOLOGY SV	300,327	314,855	3.17
3.18	54.00	RADIOLOGY-DIAGNOSTIC	SFI HEALTHCARE TECHNOLOGY SV	430,433	451,256	3.18
3.19	60.00	LABORATORY	SFI HEALTHCARE TECHNOLOGY SV	82,913	86,924	3.19
3.20	30.00	ADULTS & PEDIATRICS	EICU	1,193	1,856	3.20
3.21	5.00	ADMINISTRATIVE & GENERAL	PURCH SVCS-ST GABRIEL	261,764	262,380	3.21
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	OSFMG MINISTRY ALLOCATION	687	15,976	4.00
4.01	30.00	ADULTS & PEDIATRICS	OSFMG MINISTRY ALLOCATION	13,840	47,719	4.01
4.02	53.00	ANESTHESIOLOGY	OSFMG MINISTRY ALLOCATION	155	2,432	4.02
4.03	88.00	RURAL HEALTH CLINIC	OSFMG MINISTRY ALLOCATION	438,506	816,765	4.03
4.04	91.00	EMERGENCY	OSFMG MINISTRY ALLOCATION	2,089	32,814	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,287,489	8,749,215	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/24/2024 6:39 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-182,996	9		1.00
2.00	403,630	9		2.00
3.00	-1,077,956	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	26,712	0		3.03
3.04	1,478	0		3.04
3.05	259	0		3.05
3.06	94	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	372,921	0		3.10
3.11	0	0		3.11
3.12	-90,879	0		3.12
3.13	1,584,415	0		3.13
3.14	1,613	0		3.14
3.15	-8	0		3.15
3.16	61	0		3.16
3.17	-14,528	0		3.17
3.18	-20,823	0		3.18
3.19	-4,011	0		3.19
3.20	-663	0		3.20
3.21	-616	0		3.21
4.00	-15,289	9		4.00
4.01	-33,879	0		4.01
4.02	-2,277	0		4.02
4.03	-378,259	0		4.03
4.04	-30,725	0		4.04
5.00	538,274			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 2/24/2024 6:39 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	506,198	506,198	0	0	0	1.00
2.00	50.00	OPERATING ROOM	73,561	73,561	0	0	0	2.00
3.00	60.00	LABORATORY	23,000	23,000	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	189	189	0	0	0	4.00
5.00	91.00	EMERGENCY	2,305,053	1,731,095	573,958	0	0	5.00
6.00	91.00	EMERGENCY	45,000	0	45,000	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,953,001	2,334,043	618,958		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	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	506,198		1.00
2.00	50.00	OPERATING ROOM	0	0	0	73,561		2.00
3.00	60.00	LABORATORY	0	0	0	23,000		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	189		4.00
5.00	91.00	EMERGENCY	0	0	0	1,731,095		5.00
6.00	91.00	EMERGENCY	0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,334,043		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/24/2024 6:39 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,398,319	1,398,319				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	936,099		936,099			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,013,391	0	90	4,013,481		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,654,783	244,119	60,623	249,252	9,208,777	5.00
7.00	00700	OPERATION OF PLANT	1,523,855	116,037	77,322	77,405	1,794,619	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	96,907	5,909	0	2,878	105,694	8.00
9.00	00900	HOUSEKEEPING	524,278	11,361	0	115,263	650,902	9.00
10.00	01000	DIETARY	159,014	31,628	11,889	26,440	228,971	10.00
11.00	01100	CAFETERIA	206,134	10,790	0	54,504	271,428	11.00
13.00	01300	NURSING ADMINISTRATION	575,850	4,111	0	53,294	633,255	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	192,377	0	11,414	35,131	238,922	14.00
15.00	01500	PHARMACY	1,348,285	19,425	56,048	64,532	1,488,290	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	56,490	7,022	0	0	63,512	16.00
17.00	01700	SOCIAL SERVICE	257,713	0	0	0	257,713	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,597,640	257,693	167,471	376,604	2,399,408	30.00
31.00	03100	INTENSIVE CARE UNIT	33,658	36,424	0	8,540	78,622	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	733,999	136,803	252,413	150,014	1,273,229	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4,416	1,927	6,566	264	13,173	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	913,464	65,212	68,066	126,109	1,172,851	54.00
54.01	03440	MAMMOGRAPHY	116,568	2,469	0	28,228	147,265	54.01
56.00	05600	RADIOISOTOPE	205,672	3,854	0	0	209,526	56.00
56.01	03630	ULTRA SOUND	234,606	3,340	222	60,579	298,747	56.01
57.00	05700	CT SCAN	283,875	5,395	0	56,581	345,851	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	183,995	26,861	2,408	42,142	255,406	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,868,078	28,203	91,353	243,183	2,230,817	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	72,775	2,569	0	483	75,827	62.00
65.00	06500	RESPIRATORY THERAPY	337,289	7,964	21,372	75,464	442,089	65.00
66.00	06600	PHYSICAL THERAPY	665,031	48,070	10,048	174,289	897,438	66.00
67.00	06700	OCCUPATIONAL THERAPY	138,189	4,367	0	34,618	177,174	67.00
68.00	06800	SPEECH PATHOLOGY	50,484	1,541	934	12,280	65,239	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	259,884	28,888	30,388	67,093	386,253	69.01
69.02	03650	VASCULAR LAB	0	1,541	0	0	1,541	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,828	0	0	0	31,828	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,613	0	0	0	1,613	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,548,299	133,934	31,055	1,371,833	8,085,121	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	2,760,310	100,808	29,467	487,083	3,377,668	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,985,168	1,348,265	929,149	3,994,086	36,908,769	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	87,813	12,917	0	19,174	119,904	190.00
190.01	19001	FOUNDATION	70,830	0	6,950	0	77,780	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,132	37,137	0	0	43,269	192.00
194.00	07950	INDUSTRIAL MEDICINE	635	0	0	221	856	194.00
194.01	07951	RESEARCH	0	0	0	0	0	194.01
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)	37,150,578	1,398,319	936,099	4,013,481	37,150,578	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/24/2024 6:39 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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	9,208,777					5.00
7.00	00700	OPERATION OF PLANT	591,453	2,386,072				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,834	13,581	154,109			8.00
9.00	00900	HOUSEKEEPING	214,518	26,112	16,597	908,129		9.00
10.00	01000	DIETARY	75,462	72,693	0	29,816	406,942	10.00
11.00	01100	CAFETERIA	89,455	24,800	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	208,702	9,447	0	9,699	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	78,742	0	66	11,136	0	14.00
15.00	01500	PHARMACY	490,496	44,646	0	8,621	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,932	16,139	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	84,934	0	0	6,107	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	790,773	592,270	38,241	304,267	402,105	30.00
31.00	03100	INTENSIVE CARE UNIT	25,911	83,715	0	14,369	4,837	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	419,618	314,423	5,813	116,031	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4,341	4,428	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	386,537	149,880	17,722	60,350	0	54.00
54.01	03440	MAMMOGRAPHY	48,534	5,675	0	0	0	54.01
56.00	05600	RADIOISOTOPE	69,053	8,857	0	0	0	56.00
56.01	03630	ULTRA SOUND	98,458	7,676	0	0	0	56.01
57.00	05700	CT SCAN	113,982	12,400	0	8,981	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	84,174	61,736	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	735,210	64,820	0	41,670	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	24,990	5,905	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	145,699	18,304	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	295,769	110,483	18,856	30,534	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	58,391	10,038	0	8,262	0	67.00
68.00	06800	SPEECH PATHOLOGY	21,501	3,543	0	7,544	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	127,297	66,395	7,883	23,350	0	69.01
69.02	03650	VASCULAR LAB	508	3,543	0	8,981	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,490	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	532	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,664,610	307,829	0	53,166	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,113,178	231,692	48,931	145,847	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,129,084	2,271,030	154,109	888,731	406,942	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	39,517	29,687	0	0	0	190.00
190.01	19001	FOUNDATION	25,634	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,260	85,355	0	19,398	0	192.00
194.00	07950	INDUSTRIAL MEDICINE	282	0	0	0	0	194.00
194.01	07951	RESEARCH	0	0	0	0	0	194.01
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)	9,208,777	2,386,072	154,109	908,129	406,942	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/24/2024 6:39 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
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
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	385,683					11.00
13.00	01300	NURSING ADMINISTRATION	6,468	867,571				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,584	0	337,450			14.00
15.00	01500	PHARMACY	6,468	43,439	6,603	2,088,563		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	100,583	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,364	304,671	19,003	0	2,208	30.00
31.00	03100	INTENSIVE CARE UNIT	1,043	7,006	0	0	57	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,254	129,315	52,816	0	3,913	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	507	0	723	0	779	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,436	0	1,069	0	3,608	54.00
54.01	03440	MAMMOGRAPHY	3,785	0	1,225	0	1,021	54.01
56.00	05600	RADIOISOTOPE	0	0	577	0	1,385	56.00
56.01	03630	ULTRA SOUND	7,213	0	1,798	0	1,966	56.01
57.00	05700	CT SCAN	8,346	0	19,890	0	15,439	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,872	0	3,900	0	5,491	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	38,360	0	131,707	0	21,388	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	89	0	0	0	289	62.00
65.00	06500	RESPIRATORY THERAPY	10,492	0	5,105	0	1,943	65.00
66.00	06600	PHYSICAL THERAPY	24,500	0	568	0	2,652	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,173	0	176	0	657	67.00
68.00	06800	SPEECH PATHOLOGY	1,639	0	10	0	121	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	9,866	0	414	0	4,216	69.01
69.02	03650	VASCULAR LAB	0	0	0	0	798	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	342	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,088,563	6,608	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	105,092	0	26,043	0	11,965	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	57,048	383,140	65,732	0	13,737	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	381,599	867,571	337,359	2,088,563	100,583	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,054	0	6	0	0	190.00
190.01	19001	FOUNDATION	0	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	85	0	0	192.00
194.00	07950	INDUSTRIAL MEDICINE	30	0	0	0	0	194.00
194.01	07951	RESEARCH	0	0	0	0	0	194.01
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)	385,683	867,571	337,450	2,088,563	100,583	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/24/2024 6:39 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
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
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
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	348,754					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	344,608	5,242,918	0	5,242,918		30.00
31.00	03100	INTENSIVE CARE UNIT	4,146	219,706	0	219,706		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,334,412	0	2,334,412		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	23,951	0	23,951		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,809,453	0	1,809,453		54.00
54.01	03440	MAMMOGRAPHY	0	207,505	0	207,505		54.01
56.00	05600	RADIOISOTOPE	0	289,398	0	289,398		56.00
56.01	03630	ULTRA SOUND	0	415,858	0	415,858		56.01
57.00	05700	CT SCAN	0	524,889	0	524,889		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	416,579	0	416,579		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	3,263,972	0	3,263,972		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	107,100	0	107,100		62.00
65.00	06500	RESPIRATORY THERAPY	0	623,632	0	623,632		65.00
66.00	06600	PHYSICAL THERAPY	0	1,380,800	0	1,380,800		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	258,871	0	258,871		67.00
68.00	06800	SPEECH PATHOLOGY	0	99,597	0	99,597		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	625,674	0	625,674		69.01
69.02	03650	VASCULAR LAB	0	15,371	0	15,371		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	42,660	0	42,660		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,097,316	0	2,097,316		73.00
73.01	03480	ONCOLOGY	0	0	0	0		73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	11,253,826	0	11,253,826		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
91.00	09100	EMERGENCY	0	5,436,973	0	5,436,973		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	348,754	36,690,461	0	36,690,461		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	193,168	0	193,168		190.00
190.01	19001	FOUNDATION	0	103,414	0	103,414		190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	162,367	0	162,367		192.00
194.00	07950	INDUSTRIAL MEDICINE	0	1,168	0	1,168		194.00
194.01	07951	RESEARCH	0	0	0	0		194.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	348,754	37,150,578	0	37,150,578		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/24/2024 6:39 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	90	90	90	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	244,119	60,623	304,742	6	5.00
7.00	00700	OPERATION OF PLANT	0	116,037	77,322	193,359	2	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,909	0	5,909	0	8.00
9.00	00900	HOUSEKEEPING	0	11,361	0	11,361	3	9.00
10.00	01000	DIETARY	0	31,628	11,889	43,517	1	10.00
11.00	01100	CAFETERIA	0	10,790	0	10,790	1	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,111	0	4,111	1	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	11,414	11,414	1	14.00
15.00	01500	PHARMACY	0	19,425	56,048	75,473	1	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,022	0	7,022	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	257,693	167,471	425,164	8	30.00
31.00	03100	INTENSIVE CARE UNIT	0	36,424	0	36,424	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	136,803	252,413	389,216	3	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,927	6,566	8,493	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	65,212	68,066	133,278	3	54.00
54.01	03440	MAMMOGRAPHY	0	2,469	0	2,469	1	54.01
56.00	05600	RADIOISOTOPE	0	3,854	0	3,854	0	56.00
56.01	03630	ULTRA SOUND	0	3,340	222	3,562	1	56.01
57.00	05700	CT SCAN	0	5,395	0	5,395	1	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	26,861	2,408	29,269	1	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	28,203	91,353	119,556	5	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	2,569	0	2,569	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	7,964	21,372	29,336	2	65.00
66.00	06600	PHYSICAL THERAPY	0	48,070	10,048	58,118	4	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,367	0	4,367	1	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,541	934	2,475	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	28,888	30,388	59,276	2	69.01
69.02	03650	VASCULAR LAB	0	1,541	0	1,541	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	133,934	31,055	164,989	31	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	100,808	29,467	130,275	11	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,348,265	929,149	2,277,414	90	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,917	0	12,917	0	190.00
190.01	19001	FOUNDATION	0	0	6,950	6,950	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	37,137	0	37,137	0	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	0	0	0	0	194.00
194.01	07951	RESEARCH	0	0	0	0	0	194.01
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	1,398,319	936,099	2,334,418	90	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/24/2024 6:39 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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	304,748					5.00
7.00	00700	OPERATION OF PLANT	19,574	212,935				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,153	1,212	8,274			8.00
9.00	00900	HOUSEKEEPING	7,099	2,330	891	21,684		9.00
10.00	01000	DIETARY	2,497	6,487	0	712	53,214	10.00
11.00	01100	CAFETERIA	2,960	2,213	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,907	843	0	232	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,606	0	4	266	0	14.00
15.00	01500	PHARMACY	16,233	3,984	0	206	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	693	1,440	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	2,811	0	0	146	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,170	52,857	2,053	7,266	52,581	30.00
31.00	03100	INTENSIVE CARE UNIT	858	7,471	0	343	633	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,887	28,059	312	2,771	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	144	395	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,792	13,375	951	1,441	0	54.00
54.01	03440	MAMMOGRAPHY	1,606	506	0	0	0	54.01
56.00	05600	RADIOISOTOPE	2,285	790	0	0	0	56.00
56.01	03630	ULTRA SOUND	3,258	685	0	0	0	56.01
57.00	05700	CT SCAN	3,772	1,107	0	214	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,786	5,509	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	24,332	5,785	0	995	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	827	527	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	4,822	1,634	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	9,788	9,860	1,012	729	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,932	896	0	197	0	67.00
68.00	06800	SPEECH PATHOLOGY	712	316	0	180	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,213	5,925	423	558	0	69.01
69.02	03650	VASCULAR LAB	17	316	0	214	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	347	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	88,172	27,471	0	1,269	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	36,840	20,676	2,628	3,482	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	302,111	202,669	8,274	21,221	53,214	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,308	2,649	0	0	0	190.00
190.01	19001	FOUNDATION	848	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	472	7,617	0	463	0	192.00
194.00	07950	INDUSTRIAL MEDICINE	9	0	0	0	0	194.00
194.01	07951	RESEARCH	0	0	0	0	0	194.01
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)	304,748	212,935	8,274	21,684	53,214	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/24/2024 6:39 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
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
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	15,964					11.00
13.00	01300	NURSING ADMINISTRATION	268	12,362				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	355	0	14,646			14.00
15.00	01500	PHARMACY	268	619	287	97,071		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	9,155	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,878	4,341	825	0	200	30.00
31.00	03100	INTENSIVE CARE UNIT	43	100	0	0	5	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	797	1,843	2,292	0	355	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	21	0	31	0	71	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	722	0	46	0	328	54.00
54.01	03440	MAMMOGRAPHY	157	0	53	0	93	54.01
56.00	05600	RADIOISOTOPE	0	0	25	0	126	56.00
56.01	03630	ULTRA SOUND	299	0	78	0	178	56.01
57.00	05700	CT SCAN	345	0	863	0	1,402	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	243	0	169	0	499	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,588	0	5,717	0	1,963	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	4	0	0	0	26	62.00
65.00	06500	RESPIRATORY THERAPY	434	0	222	0	176	65.00
66.00	06600	PHYSICAL THERAPY	1,014	0	25	0	241	66.00
67.00	06700	OCCUPATIONAL THERAPY	173	0	8	0	60	67.00
68.00	06800	SPEECH PATHOLOGY	68	0	0	0	11	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	408	0	18	0	383	69.01
69.02	03650	VASCULAR LAB	0	0	0	0	72	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	31	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	97,071	600	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,349	0	1,130	0	1,087	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	2,361	5,459	2,853	0	1,248	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,795	12,362	14,642	97,071	9,155	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	168	0	0	0	0	190.00
190.01	19001	FOUNDATION	0	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4	0	0	192.00
194.00	07950	INDUSTRIAL MEDICINE	1	0	0	0	0	194.00
194.01	07951	RESEARCH	0	0	0	0	0	194.01
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)	15,964	12,362	14,646	97,071	9,155	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/24/2024 6:39 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
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
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
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	2,957					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,922	576,265	0	576,265		30.00
31.00	03100	INTENSIVE CARE UNIT	35	45,912	0	45,912		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	439,535	0	439,535		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	9,155	0	9,155		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	162,936	0	162,936		54.00
54.01	03440	MAMMOGRAPHY	0	4,885	0	4,885		54.01
56.00	05600	RADIOISOTOPE	0	7,080	0	7,080		56.00
56.01	03630	ULTRA SOUND	0	8,061	0	8,061		56.01
57.00	05700	CT SCAN	0	13,099	0	13,099		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	38,476	0	38,476		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	159,941	0	159,941		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	3,953	0	3,953		62.00
65.00	06500	RESPIRATORY THERAPY	0	36,626	0	36,626		65.00
66.00	06600	PHYSICAL THERAPY	0	80,791	0	80,791		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,634	0	7,634		67.00
68.00	06800	SPEECH PATHOLOGY	0	3,762	0	3,762		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	71,206	0	71,206		69.01
69.02	03650	VASCULAR LAB	0	2,160	0	2,160		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	378	0	378		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	97,689	0	97,689		73.00
73.01	03480	ONCOLOGY	0	0	0	0		73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	288,498	0	288,498		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
91.00	09100	EMERGENCY	0	205,833	0	205,833		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,957	2,263,875	0	2,263,875		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,042	0	17,042		190.00
190.01	19001	FOUNDATION	0	7,798	0	7,798		190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	45,693	0	45,693		192.00
194.00	07950	INDUSTRIAL MEDICINE	0	10	0	10		194.00
194.01	07951	RESEARCH	0	0	0	0		194.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,957	2,334,418	0	2,334,418		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/24/2024 6:39 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	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	97,972					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		569,984				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	55	15,044,884			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,104	36,913	934,344	-9,208,777	27,941,801	5.00
7.00	00700	OPERATION OF PLANT	8,130	47,081	290,161	0	1,794,619	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	0	10,787	0	105,694	8.00
9.00	00900	HOUSEKEEPING	796	0	432,072	0	650,902	9.00
10.00	01000	DIETARY	2,216	7,239	99,111	0	228,971	10.00
11.00	01100	CAFETERIA	756	0	204,312	0	271,428	11.00
13.00	01300	NURSING ADMINISTRATION	288	0	199,777	0	633,255	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,950	131,690	0	238,922	14.00
15.00	01500	PHARMACY	1,361	34,127	241,904	0	1,488,290	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	492	0	0	0	63,512	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	257,713	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,055	101,972	1,411,733	0	2,399,408	30.00
31.00	03100	INTENSIVE CARE UNIT	2,552	0	32,014	0	78,622	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,585	153,693	562,341	0	1,273,229	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	135	3,998	988	0	13,173	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,569	41,445	472,731	0	1,172,851	54.00
54.01	03440	MAMMOGRAPHY	173	0	105,817	0	147,265	54.01
56.00	05600	RADIOISOTOPE	270	0	0	0	209,526	56.00
56.01	03630	ULTRA SOUND	234	135	227,086	0	298,747	56.01
57.00	05700	CT SCAN	378	0	212,100	0	345,851	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,882	1,466	157,974	0	255,406	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,976	55,624	911,595	0	2,230,817	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	180	0	1,810	0	75,827	62.00
65.00	06500	RESPIRATORY THERAPY	558	13,013	282,885	0	442,089	65.00
66.00	06600	PHYSICAL THERAPY	3,368	6,118	653,338	0	897,438	66.00
67.00	06700	OCCUPATIONAL THERAPY	306	0	129,770	0	177,174	67.00
68.00	06800	SPEECH PATHOLOGY	108	569	46,034	0	65,239	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	2,024	18,503	251,503	0	386,253	69.01
69.02	03650	VASCULAR LAB	108	0	0	0	1,541	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	31,828	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,613	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,384	18,909	5,142,425	0	8,085,121	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	7,063	17,942	1,825,876	0	3,377,668	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	94,465	565,752	14,972,178	-9,208,777	27,699,992	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	905	0	71,876	0	119,904	190.00
190.01	19001	FOUNDATION	0	4,232	0	0	77,780	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,602	0	0	0	43,269	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	0	830	0	856	194.00
194.01	07951	RESEARCH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,398,319	936,099	4,013,481		9,208,777	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.272639	1.642325	0.266767		0.329570	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			90		304,748	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/24/2024 6:39 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000006		0.010907	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: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/24/2024 6:39 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		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
7.00	00700	OPERATION OF PLANT	72,738					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	16,305				8.00
9.00	00900	HOUSEKEEPING	796	1,756	2,528			9.00
10.00	01000	DIETARY	2,216	0	83	1,346		10.00
11.00	01100	CAFETERIA	756	0	0	0	12,940	11.00
13.00	01300	NURSING ADMINISTRATION	288	0	27	0	217	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7	31	0	288	14.00
15.00	01500	PHARMACY	1,361	0	24	0	217	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	492	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	17	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,055	4,046	847	1,330	1,522	30.00
31.00	03100	INTENSIVE CARE UNIT	2,552	0	40	16	35	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,585	615	323	0	646	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	135	0	0	0	17	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,569	1,875	168	0	585	54.00
54.01	03440	MAMMOGRAPHY	173	0	0	0	127	54.01
56.00	05600	RADIOISOTOPE	270	0	0	0	0	56.00
56.01	03630	ULTRA SOUND	234	0	0	0	242	56.01
57.00	05700	CT SCAN	378	0	25	0	280	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,882	0	0	0	197	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,976	0	116	0	1,287	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	180	0	0	0	3	62.00
65.00	06500	RESPIRATORY THERAPY	558	0	0	0	352	65.00
66.00	06600	PHYSICAL THERAPY	3,368	1,995	85	0	822	66.00
67.00	06700	OCCUPATIONAL THERAPY	306	0	23	0	140	67.00
68.00	06800	SPEECH PATHOLOGY	108	0	21	0	55	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	2,024	834	65	0	331	69.01
69.02	03650	VASCULAR LAB	108	0	25	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,384	0	148	0	3,526	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	7,063	5,177	406	0	1,914	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,231	16,305	2,474	1,346	12,803	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	905	0	0	0	136	190.00
190.01	19001	FOUNDATION	0	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,602	0	54	0	0	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	0	0	0	1	194.00
194.01	07951	RESEARCH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,386,072	154,109	908,129	406,942	385,683	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.803651	9.451641	359.228244	302.334324	29.805487	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	212,935	8,274	21,684	53,214	15,964	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.927424	0.507452	8.577532	39.534918	1.233694	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/24/2024 6:39 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
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: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/24/2024 6:39 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		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
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
13.00	01300	NURSING ADMINISTRATION	4,334					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,081,957				14.00
15.00	01500	PHARMACY	217	21,170	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	106,265,905		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	1,346	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,522	60,928	0	2,331,211	1,330	30.00
31.00	03100	INTENSIVE CARE UNIT	35	0	0	60,655	16	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	646	169,342	0	4,132,070	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,319	0	822,927	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,427	0	3,809,688	0	54.00
54.01	03440	MAMMOGRAPHY	0	3,927	0	1,078,666	0	54.01
56.00	05600	RADIOISOTOPE	0	1,851	0	1,462,993	0	56.00
56.01	03630	ULTRA SOUND	0	5,766	0	2,075,506	0	56.01
57.00	05700	CT SCAN	0	63,774	0	16,303,131	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	12,506	0	5,797,886	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	422,285	0	22,636,992	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	305,390	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	16,368	0	2,052,245	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,821	0	2,800,170	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	563	0	694,131	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	31	0	127,555	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	1,328	0	4,451,623	0	69.01
69.02	03650	VASCULAR LAB	0	0	0	842,625	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	361,017	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	6,978,321	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	83,502	0	12,634,815	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,914	210,756	0	14,506,288	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,334	1,081,664	100	106,265,905	1,346	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19	0	0	0	190.00
190.01	19001	FOUNDATION	0	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	274	0	0	0	192.00
194.00	07950	INDUSTRIAL MEDICINE	0	0	0	0	0	194.00
194.01	07951	RESEARCH	0	0	0	0	0	194.01
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)	867,571	337,450	2,088,563	100,583	348,754	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	200.177896	0.311889	20,885.630000	0.000947	259.104012	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,362	14,646	97,071	9,155	2,957	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.852330	0.013537	970.710000	0.000086	2.196880	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/24/2024 6:39 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
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: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/24/2024 6:39 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	5,242,918		5,242,918	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	219,706		219,706	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,334,412		2,334,412	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	23,951		23,951	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,809,453		1,809,453	0	0	54.00
54.01	03440	MAMMOGRAPHY	207,505		207,505	0	0	54.01
56.00	05600	RADIOISOTOPE	289,398		289,398	0	0	56.00
56.01	03630	ULTRA SOUND	415,858		415,858	0	0	56.01
57.00	05700	CT SCAN	524,889		524,889	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	416,579		416,579	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	3,263,972		3,263,972	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	107,100		107,100	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	623,632	0	623,632	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,380,800	0	1,380,800	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	258,871	0	258,871	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	99,597	0	99,597	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	625,674		625,674	0	0	69.01
69.02	03650	VASCULAR LAB	15,371		15,371	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,660		42,660	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,097,316		2,097,316	0	0	73.00
73.01	03480	ONCOLOGY	0		0	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	11,253,826		11,253,826	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	5,436,973		5,436,973	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,299,336		1,299,336		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	37,989,797	0	37,989,797	0	0	200.00
201.00		Less Observation Beds	1,299,336		1,299,336		0	201.00
202.00		Total (see instructions)	36,690,461	0	36,690,461	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/24/2024 6:39 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	1,993,249		1,993,249			30.00
31.00	03100	INTENSIVE CARE UNIT	60,655		60,655			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	48,163	4,083,907	4,132,070	0.564950	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	16,923	806,004	822,927	0.029105	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100,478	3,709,210	3,809,688	0.474961	0.000000	54.00
54.01	03440	MAMMOGRAPHY	0	1,078,666	1,078,666	0.192372	0.000000	54.01
56.00	05600	RADIOISOTOPE	24,927	1,438,066	1,462,993	0.197812	0.000000	56.00
56.01	03630	ULTRA SOUND	21,854	2,053,652	2,075,506	0.200365	0.000000	56.01
57.00	05700	CT SCAN	444,130	15,859,001	16,303,131	0.032196	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	90,884	5,707,002	5,797,886	0.071850	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,111,592	21,525,400	22,636,992	0.144188	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	33,157	272,233	305,390	0.350699	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	444,207	1,608,038	2,052,245	0.303878	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	258,779	2,541,391	2,800,170	0.493113	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	189,414	504,717	694,131	0.372943	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	15,263	112,292	127,555	0.780816	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	03160	CARDIOPULMONARY	235,487	4,216,136	4,451,623	0.140550	0.000000	69.01
69.02	03650	VASCULAR LAB	24,340	818,285	842,625	0.018242	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	361,017	361,017	0.118166	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	994,168	5,984,153	6,978,321	0.300547	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	12,634,815	12,634,815			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
91.00	09100	EMERGENCY	356,808	14,149,480	14,506,288	0.374801	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	50,762	287,200	337,962	3.844622	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,515,240	99,750,665	106,265,905			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,515,240	99,750,665	106,265,905			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/24/2024 6:39 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
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	03440	MAMMOGRAPHY	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
56.01	03630	ULTRA SOUND	0.000000	56.01
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0.000000	69.01
69.02	03650	VASCULAR LAB	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
73.01	03480	ONCOLOGY	0.000000	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/24/2024 6:39 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,242,918		5,242,918	0	5,242,918	30.00
31.00	03100	INTENSIVE CARE UNIT	219,706		219,706	0	219,706	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,334,412		2,334,412	0	2,334,412	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	23,951		23,951	0	23,951	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,809,453		1,809,453	0	1,809,453	54.00
54.01	03440	MAMMOGRAPHY	207,505		207,505	0	207,505	54.01
56.00	05600	RADIOISOTOPE	289,398		289,398	0	289,398	56.00
56.01	03630	ULTRA SOUND	415,858		415,858	0	415,858	56.01
57.00	05700	CT SCAN	524,889		524,889	0	524,889	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	416,579		416,579	0	416,579	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	3,263,972		3,263,972	0	3,263,972	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	107,100		107,100	0	107,100	62.00
65.00	06500	RESPIRATORY THERAPY	623,632	0	623,632	0	623,632	65.00
66.00	06600	PHYSICAL THERAPY	1,380,800	0	1,380,800	0	1,380,800	66.00
67.00	06700	OCCUPATIONAL THERAPY	258,871	0	258,871	0	258,871	67.00
68.00	06800	SPEECH PATHOLOGY	99,597	0	99,597	0	99,597	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	625,674		625,674	0	625,674	69.01
69.02	03650	VASCULAR LAB	15,371		15,371	0	15,371	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,660		42,660	0	42,660	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,097,316		2,097,316	0	2,097,316	73.00
73.01	03480	ONCOLOGY	0		0	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	11,253,826		11,253,826	0	11,253,826	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	5,436,973		5,436,973	0	5,436,973	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,299,336		1,299,336		1,299,336	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	37,989,797	0	37,989,797	0	37,989,797	200.00
201.00		Less Observation Beds	1,299,336		1,299,336		1,299,336	201.00
202.00		Total (see instructions)	36,690,461	0	36,690,461	0	36,690,461	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/24/2024 6:39 pm

Title XIX | 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	1,993,249		1,993,249			30.00
31.00	03100	INTENSIVE CARE UNIT	60,655		60,655			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	48,163	4,083,907	4,132,070	0.564950	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	16,923	806,004	822,927	0.029105	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100,478	3,709,210	3,809,688	0.474961	0.000000	54.00
54.01	03440	MAMMOGRAPHY	0	1,078,666	1,078,666	0.192372	0.000000	54.01
56.00	05600	RADIOISOTOPE	24,927	1,438,066	1,462,993	0.197812	0.000000	56.00
56.01	03630	ULTRA SOUND	21,854	2,053,652	2,075,506	0.200365	0.000000	56.01
57.00	05700	CT SCAN	444,130	15,859,001	16,303,131	0.032196	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	90,884	5,707,002	5,797,886	0.071850	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,111,592	21,525,400	22,636,992	0.144188	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	33,157	272,233	305,390	0.350699	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	444,207	1,608,038	2,052,245	0.303878	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	258,779	2,541,391	2,800,170	0.493113	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	189,414	504,717	694,131	0.372943	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	15,263	112,292	127,555	0.780816	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	03160	CARDIOPULMONARY	235,487	4,216,136	4,451,623	0.140550	0.000000	69.01
69.02	03650	VASCULAR LAB	24,340	818,285	842,625	0.018242	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	361,017	361,017	0.118166	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	994,168	5,984,153	6,978,321	0.300547	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	12,634,815	12,634,815	0.890700	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
91.00	09100	EMERGENCY	356,808	14,149,480	14,506,288	0.374801	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	50,762	287,200	337,962	3.844622	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,515,240	99,750,665	106,265,905			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,515,240	99,750,665	106,265,905			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/24/2024 6:39 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	03440	MAMMOGRAPHY	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
56.01	03630	ULTRA SOUND	0.000000	56.01
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0.000000	69.01
69.02	03650	VASCULAR LAB	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
73.01	03480	ONCOLOGY	0.000000	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	89.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/24/2024 6:39 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	439,535	4,132,070	0.106372	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	9,155	822,927	0.011125	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	162,936	3,809,688	0.042769	21,140	904	54.00
54.01	03440	MAMMOGRAPHY	4,885	1,078,666	0.004529	0	0	54.01
56.00	05600	RADIOISOTOPE	7,080	1,462,993	0.004839	14,789	72	56.00
56.01	03630	ULTRA SOUND	8,061	2,075,506	0.003884	8,354	32	56.01
57.00	05700	CT SCAN	13,099	16,303,131	0.000803	63,091	51	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	38,476	5,797,886	0.006636	18,533	123	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	159,941	22,636,992	0.007065	304,404	2,151	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,953	305,390	0.012944	16,734	217	62.00
65.00	06500	RESPIRATORY THERAPY	36,626	2,052,245	0.017847	152,879	2,728	65.00
66.00	06600	PHYSICAL THERAPY	80,791	2,800,170	0.028852	68,975	1,990	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,634	694,131	0.010998	43,485	478	67.00
68.00	06800	SPEECH PATHOLOGY	3,762	127,555	0.029493	6,219	183	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	71,206	4,451,623	0.015996	85,190	1,363	69.01
69.02	03650	VASCULAR LAB	2,160	842,625	0.002563	8,115	21	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	378	361,017	0.001047	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	97,689	6,978,321	0.013999	305,905	4,282	73.00
73.01	03480	ONCOLOGY	0	0	0.000000	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	288,498	12,634,815	0.022834	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	205,833	14,506,288	0.014189	10,874	154	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	142,814	337,962	0.422574	1,389	587	92.00
200.00		Total (lines 50 through 199)	1,784,512	104,212,001		1,130,076	15,336	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/24/2024 6:39 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03440	MAMMOGRAPHY	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	03630	ULTRA SOUND	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
69.02	03650	VASCULAR LAB	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
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)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/24/2024 6:39 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	4,132,070	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	822,927	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,809,688	0.000000	54.00
54.01	03440	MAMMOGRAPHY	0	0	0	1,078,666	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	1,462,993	0.000000	56.00
56.01	03630	ULTRA SOUND	0	0	0	2,075,506	0.000000	56.01
57.00	05700	CT SCAN	0	0	0	16,303,131	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	5,797,886	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	22,636,992	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	305,390	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,052,245	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,800,170	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	694,131	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	127,555	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	4,451,623	0.000000	69.01
69.02	03650	VASCULAR LAB	0	0	0	842,625	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	361,017	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,978,321	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0.000000	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	12,634,815	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
91.00	09100	EMERGENCY	0	0	0	14,506,288	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	337,962	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	104,212,001		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/24/2024 6:39 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	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	21,140	0	0	0	54.00
54.01	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	14,789	0	0	0	56.00
56.01	03630	ULTRA SOUND	0.000000	8,354	0	0	0	56.01
57.00	05700	CT SCAN	0.000000	63,091	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	18,533	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	304,404	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	16,734	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	152,879	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	68,975	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	43,485	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	6,219	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.000000	85,190	0	0	0	69.01
69.02	03650	VASCULAR LAB	0.000000	8,115	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	305,905	0	0	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
91.00	09100	EMERGENCY	0.000000	10,874	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,389	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,130,076	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/24/2024 6:39 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	0.564950	0	1,233,516	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029105	0	222,564	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.474961	0	803,765	0	0	54.00
54.01	03440	MAMMOGRAPHY	0.192372	0	188,051	0	0	54.01
56.00	05600	RADIOISOTOPE	0.197812	0	473,296	0	0	56.00
56.01	03630	ULTRA SOUND	0.200365	0	240,970	0	0	56.01
57.00	05700	CT SCAN	0.032196	0	4,536,387	488	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071850	0	1,313,434	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.144188	0	5,595,108	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.350699	0	117,000	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.303878	0	328,118	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.493113	0	534,330	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.372943	0	72,089	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.780816	0	40,041	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.140550	0	1,332,290	0	0	69.01
69.02	03650	VASCULAR LAB	0.018242	0	282,736	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.118166	0	126,696	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.300547	0	2,940,749	4,203	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
91.00	09100	EMERGENCY	0.374801	0	2,832,269	558	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3.844622	0	73,451	0	0	92.00
200.00		Subtotal (see instructions)		0	23,286,860	5,249	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	23,286,860	5,249	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/24/2024 6:39 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	696,875	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	6,478	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	381,757	0		54.00
54.01	03440	MAMMOGRAPHY	36,176	0		54.01
56.00	05600	RADIOISOTOPE	93,624	0		56.00
56.01	03630	ULTRA SOUND	48,282	0		56.01
57.00	05700	CT SCAN	146,054	16		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	94,370	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	806,747	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	41,032	0		62.00
65.00	06500	RESPIRATORY THERAPY	99,708	0		65.00
66.00	06600	PHYSICAL THERAPY	263,485	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	26,885	0		67.00
68.00	06800	SPEECH PATHOLOGY	31,265	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	187,253	0		69.01
69.02	03650	VASCULAR LAB	5,158	0		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,971	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	883,833	1,263		73.00
73.01	03480	ONCOLOGY	0	0		73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
91.00	09100	EMERGENCY	1,061,537	209		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	282,391	0		92.00
200.00		Subtotal (see instructions)	5,207,881	1,488		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,207,881	1,488		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part I | Date/Time Prepared: 2/24/2024 6:39 pm

Title XIX | Hospital | Cost

	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	576,265	152,818	423,447	1,258	336.60	30.00
31.00	INTENSIVE CARE UNIT	45,912		45,912	16	2,869.50	31.00
200.00	Total (lines 30 through 199)	622,177		469,359	1,274		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	9	3,029				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
200.00	Total (lines 30 through 199)	9	3,029				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/24/2024 6:39 pm

Title XIX | 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	439,535	4,132,070	0.106372	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	9,155	822,927	0.011125	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	162,936	3,809,688	0.042769	0	0	54.00
54.01	03440	MAMMOGRAPHY	4,885	1,078,666	0.004529	0	0	54.01
56.00	05600	RADIOISOTOPE	7,080	1,462,993	0.004839	0	0	56.00
56.01	03630	ULTRA SOUND	8,061	2,075,506	0.003884	0	0	56.01
57.00	05700	CT SCAN	13,099	16,303,131	0.000803	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	38,476	5,797,886	0.006636	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	159,941	22,636,992	0.007065	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,953	305,390	0.012944	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	36,626	2,052,245	0.017847	0	0	65.00
66.00	06600	PHYSICAL THERAPY	80,791	2,800,170	0.028852	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,634	694,131	0.010998	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,762	127,555	0.029493	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	71,206	4,451,623	0.015996	0	0	69.01
69.02	03650	VASCULAR LAB	2,160	842,625	0.002563	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	378	361,017	0.001047	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	97,689	6,978,321	0.013999	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0.000000	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	288,498	12,634,815	0.022834	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	205,833	14,506,288	0.014189	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	142,814	337,962	0.422574	0	0	92.00
200.00		Total (lines 50 through 199)	1,784,512	104,212,001		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part III | Date/Time Prepared: 2/24/2024 6:39 pm

Title XIX | Hospital | Cost

		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
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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	1,258	0.00	9	30.00
31.00	03100	INTENSIVE CARE UNIT		0	16	0.00	0	31.00
200.00		Total (lines 30 through 199)		0	1,274		9	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
31.00	03100	INTENSIVE CARE UNIT	0	31.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/24/2024 6:39 pm

Title XIX | 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03440	MAMMOGRAPHY	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	03630	ULTRA SOUND	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
69.02	03650	VASCULAR LAB	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
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)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/24/2024 6:39 pm

Title XIX | 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	4,132,070	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	822,927	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,809,688	0.000000	54.00
54.01	03440	MAMMOGRAPHY	0	0	0	1,078,666	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	1,462,993	0.000000	56.00
56.01	03630	ULTRA SOUND	0	0	0	2,075,506	0.000000	56.01
57.00	05700	CT SCAN	0	0	0	16,303,131	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	5,797,886	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	22,636,992	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	305,390	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,052,245	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,800,170	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	694,131	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	127,555	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	4,451,623	0.000000	69.01
69.02	03650	VASCULAR LAB	0	0	0	842,625	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	361,017	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,978,321	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0.000000	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	12,634,815	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
91.00	09100	EMERGENCY	0	0	0	14,506,288	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	337,962	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	104,212,001		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/24/2024 6:39 pm

Title XIX | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
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
54.01	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
56.01	03630	ULTRA SOUND	0.000000	0	0	0	0	56.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
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
69.01	03160	CARDIOPULMONARY	0.000000	0	0	0	0	69.01
69.02	03650	VASCULAR LAB	0.000000	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
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: 14-1325	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/24/2024 6:39 pm
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,755	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,258	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)	833	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	114	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)	340	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	11	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)	32	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	388	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)	62	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)	184	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	201.56	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	208.70	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,242,918	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)	2,217	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)	6,678	25.00
26.00	Total swing-bed cost (see instructions)	1,396,891	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,846,027	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)	3,846,027	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)	3,057.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,186,217	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)	1,186,217	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/24/2024 6:39 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	219,706	16	13,731.63	12	164,780	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)	282,781	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)	1,633,778	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)	189,550	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	562,536	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	752,086	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)	425	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,057.26	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1325	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/24/2024 6:39 pm
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,299,336	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	576,265	5,242,918	0.109913	1,299,336	142,814	90.00
91.00	Nursing Program cost	0	5,242,918	0.000000	1,299,336	0	91.00
92.00	Allied health cost	0	5,242,918	0.000000	1,299,336	0	92.00
93.00	All other Medical Education	0	5,242,918	0.000000	1,299,336	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1325	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/24/2024 6:39 pm
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,755	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,258	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)	833	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	114	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)	340	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	11	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)	32	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	9	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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,242,918	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,390,352	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,852,566	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)	3,852,566	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)	3,062.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	27,562	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)	27,562	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/24/2024 6:39 pm

Title XIX | 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	219,706	16	13,731.63	0	0	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)	27,562	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)	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)	425	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,062.45	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1325	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/24/2024 6:39 pm
	Title XIX	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,301,541	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	576,265	5,242,918	0.109913	1,301,541	143,056	90.00
91.00	Nursing Program cost	0	5,242,918	0.000000	1,301,541	0	91.00
92.00	Allied health cost	0	5,242,918	0.000000	1,301,541	0	92.00
93.00	All other Medical Education	0	5,242,918	0.000000	1,301,541	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/24/2024 6:39 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		625,638		30.00
31.00	03100	INTENSIVE CARE UNIT		45,480		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.564950	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029105	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.474961	21,140	10,041	54.00
54.01	03440	MAMMOGRAPHY	0.192372	0	0	54.01
56.00	05600	RADIOISOTOPE	0.197812	14,789	2,925	56.00
56.01	03630	ULTRA SOUND	0.200365	8,354	1,674	56.01
57.00	05700	CT SCAN	0.032196	63,091	2,031	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071850	18,533	1,332	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.144188	304,404	43,891	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.350699	16,734	5,869	62.00
65.00	06500	RESPIRATORY THERAPY	0.303878	152,879	46,457	65.00
66.00	06600	PHYSICAL THERAPY	0.493113	68,975	34,012	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.372943	43,485	16,217	67.00
68.00	06800	SPEECH PATHOLOGY	0.780816	6,219	4,856	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.140550	85,190	11,973	69.01
69.02	03650	VASCULAR LAB	0.018242	8,115	148	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.118166	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.300547	305,905	91,939	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100	EMERGENCY	0.374801	10,874	4,076	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3.844622	1,389	5,340	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,130,076	282,781	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)		1,130,076		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1325 | Component CCN: 14-Z325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/24/2024 6:39 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.564950	2,136	1,207	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029105	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.474961	1,685	800	54.00
54.01	03440	MAMMOGRAPHY	0.192372	0	0	54.01
56.00	05600	RADIOISOTOPE	0.197812	0	0	56.00
56.01	03630	ULTRA SOUND	0.200365	0	0	56.01
57.00	05700	CT SCAN	0.032196	6,285	202	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071850	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.144188	40,093	5,781	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.350699	3,164	1,110	62.00
65.00	06500	RESPIRATORY THERAPY	0.303878	11,728	3,564	65.00
66.00	06600	PHYSICAL THERAPY	0.493113	68,335	33,697	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.372943	58,616	21,860	67.00
68.00	06800	SPEECH PATHOLOGY	0.780816	3,578	2,794	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.140550	1,029	145	69.01
69.02	03650	VASCULAR LAB	0.018242	1,296	24	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.118166	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.300547	55,767	16,761	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100	EMERGENCY	0.374801	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3.844622	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		253,712	87,945	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)		253,712		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/24/2024 6:39 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.564950	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029105	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.474961	0	0	54.00
54.01	03440	MAMMOGRAPHY	0.192372	0	0	54.01
56.00	05600	RADIOISOTOPE	0.197812	0	0	56.00
56.01	03630	ULTRA SOUND	0.200365	0	0	56.01
57.00	05700	CT SCAN	0.032196	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071850	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.144188	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.350699	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.303878	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.493113	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.372943	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.780816	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.140550	0	0	69.01
69.02	03650	VASCULAR LAB	0.018242	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.118166	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.300547	0	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	73.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.890700	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	09100	EMERGENCY	0.374801	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3.844622	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: 14-1325	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/24/2024 6:39 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,209,369	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)	5,209,369	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)	5,261,463	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)	47,753	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,378,890	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,834,820	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)	1,834,820	30.00
31.00	Primary payer payments	541	31.00
32.00	Subtotal (line 30 minus line 31)	1,834,279	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)	326,616	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	212,300	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	287,480	36.00
37.00	Subtotal (see instructions)	2,046,579	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,046,579	40.00
40.01	Sequestration adjustment (see instructions)	40,932	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	2,309,948	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)	-304,301	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	24,122	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: 14-1325	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/24/2024 6:39 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: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/24/2024 6:39 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		1,107,771		2,523,672	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	06/08/2023	257,079		0	3.01
3.02		09/14/2023	43,024		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	06/08/2023	182,016	3.50
3.51			0	09/14/2023	31,708	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)		300,103		-213,724	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)		1,407,874		2,309,948	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		40,694		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		304,301	6.02
7.00	Total Medicare program liability (see instructions)		1,448,568		2,005,647	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1325 | Component CCN: 14-Z325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/24/2024 6:39 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		688,205		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	06/08/2023	136,787		0	3.01
3.02		09/14/2023	23,612		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)		160,399		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)		848,604		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		18,710		0	6.02
7.00	Total Medicare program liability (see instructions)		829,894		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1325	Period: From 10/01/2022 To 09/30/2023	Worksheet E-1 Part II Date/Time Prepared: 2/24/2024 6:39 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: 14-1325 | Component CCN: 14-Z325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-2 | Date/Time Prepared: 2/24/2024 6:39 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)	759,607	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)	88,824	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	246	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)	848,431	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	848,431	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)	848,431	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,600	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	846,831	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)	846,831	0	19.00
19.01	Sequestration adjustment (see instructions)	16,937	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	848,604	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)	-18,710	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: 14-1325	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part V Date/Time Prepared: 2/24/2024 6:39 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,633,778	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)	1,633,778	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,650,116	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)	1,650,116	19.00
20.00	Deductibles (exclude professional component)	190,284	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,459,832	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,459,832	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	28,152	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	18,299	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	26,596	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,478,131	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)	1,478,131	30.00
30.01	Sequestration adjustment (see instructions)	29,563	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,407,874	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)	40,694	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	3,063	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G | Date/Time Prepared: 2/24/2024 6:39 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	-732,193	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	9,985,299	0	0	0	4.00
5.00	Other receivable	485,099	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,521,366	0	0	0	6.00
7.00	Inventory	377,821	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	62,995,698	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)	67,590,358	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,712,018	0	0	0	12.00
13.00	Land improvements	1,390,342	0	0	0	13.00
14.00	Accumulated depreciation	-1,097,790	0	0	0	14.00
15.00	Buildings	22,045,313	0	0	0	15.00
16.00	Accumulated depreciation	-13,483,709	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	17,724,099	0	0	0	23.00
24.00	Accumulated depreciation	-14,121,474	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	334,878	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	14,503,677	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	638,104	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	916,316	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,554,420	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	83,648,455	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	446,382	0	0	0	37.00
38.00	Salaries, wages, and fees payable	158,941	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	-289,082	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	316,241	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	462,462	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	462,462	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	778,703	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	82,869,752				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)	82,869,752	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	83,648,455	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-1 | Date/Time Prepared: 2/24/2024 6:39 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		73,453,469		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,410,247				2.00
3.00	Total (sum of line 1 and line 2)		82,863,716		0		3.00
4.00	TRANSFERS	6,036		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)		6,036		0		10.00
11.00	Subtotal (line 3 plus line 10)		82,869,752		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		82,869,752		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	TRANSFERS		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/24/2024 6:39 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,423,933		1,423,933	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	566,430		566,430	5.00
6.00	Swing bed - NF	53,649		53,649	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)	2,044,012		2,044,012	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	60,655		60,655	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)	60,655		60,655	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,104,667		2,104,667	17.00
18.00	Ancillary services	4,053,766	72,679,170	76,732,936	18.00
19.00	Outpatient services	356,808	14,436,680	14,793,488	19.00
20.00	RURAL HEALTH CLINIC	0	12,634,815	12,634,815	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NRCC	0	681	681	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,515,241	99,751,346	106,266,587	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		39,065,215		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		39,065,215		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1325 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-3 | Date/Time Prepared: 2/24/2024 6:39 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	106,266,587	1.00
2.00	Less contractual allowances and discounts on patients' accounts	59,649,745	2.00
3.00	Net patient revenues (line 1 minus line 2)	46,616,842	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	39,065,215	4.00
5.00	Net income from service to patients (line 3 minus line 4)	7,551,627	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	347,039	6.00
7.00	Income from investments	64,712	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	127,816	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	60	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	779,576	24.00
24.01	340B REVENUE	543,418	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,862,621	25.00
26.00	Total (line 5 plus line 25)	9,414,248	26.00
27.00	EQUITY TRANSFER	4,000	27.00
27.01	ROUNDING	1	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	4,001	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,410,247	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1325 | Component CCN: 14-3445 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/24/2024 6:39 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,473,164	172,250	1,645,414	-68,516	1,576,898	1.00
2.00	Physician Assistant	276,136	0	276,136	-12,271	263,865	2.00
3.00	Nurse Practitioner	674,995	0	674,995	2,634	677,629	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	2,108,480	0	2,108,480	26,202	2,134,682	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	51,771	0	51,771	815	52,586	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)	4,584,546	172,250	4,756,796	-51,136	4,705,660	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	424,901	424,901	0	424,901	15.00
16.00	Transportation (Health Care Staff)	0	11,368	11,368	0	11,368	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	11,921	11,921	0	11,921	18.00
19.00	Other Health Care Costs	0	8,131	8,131	0	8,131	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	456,321	456,321	0	456,321	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	4,584,546	628,571	5,213,117	-51,136	5,161,981	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	49,548	49,548	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	49,548	49,548	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	152,667	152,667	-750	151,917	29.00
30.00	Administrative Costs	547,393	2,226,471	2,773,864	-1,206,609	1,567,255	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	547,393	2,379,138	2,926,531	-1,207,359	1,719,172	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	5,131,939	3,007,709	8,139,648	-1,208,947	6,930,701	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1325 | Component CCN: 14-3445 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/24/2024 6:39 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	-2,746	1,574,152		1.00
2.00	Physician Assistant	0	263,865		2.00
3.00	Nurse Practitioner	0	677,629		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	2,134,682		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	52,586		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)	-2,746	4,702,914		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	424,901		15.00
16.00	Transportation (Health Care Staff)	0	11,368		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	11,921		18.00
19.00	Other Health Care Costs	0	8,131		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	456,321		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-2,746	5,159,235		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	49,548		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	49,548		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	151,917		29.00
30.00	Administrative Costs	-379,656	1,187,599		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-379,656	1,339,516		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-382,402	6,548,299		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1325 | Component CCN: 14-3445 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/24/2024 6:39 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	3.76	16,613	4,200	15,792		1.00
2.00	Physician Assistant	0.90	5,380	2,100	1,890		2.00
3.00	Nurse Practitioner	4.24	12,837	2,100	8,904		3.00
4.00	Subtotal (sum of lines 1 through 3)	8.90	34,830		26,586	34,830	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	0.46	481			481	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)	9.36	35,311			35,311	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)					5,159,235	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					49,548	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					5,208,783	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.990488	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,339,516	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					4,705,527	15.00
16.00	Total overhead (sum of lines 14 and 15)					6,045,043	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					6,045,043	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					5,987,543	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					11,146,778	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1325 Component CCN: 14-3445	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/24/2024 6:39 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)		11,146,778	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		572,411	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		10,574,367	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		35,311	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)		35,311	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		299.46	7.00

		Calculation of Limit (1)		
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	328.05	340.52	8.00
9.00	Rate for Program covered visits (see instructions)	299.46	299.46	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,610	4,421	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	482,131	1,323,913	11.00
12.00	Program covered visits for mental health services (from contractor records)	21	31	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	6,289	9,283	13.00
14.00	Limit adjustment for mental health services (see instructions)	6,289	9,283	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,821,616	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,767,742	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		25,128	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		25,894	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,309,559	16.04
16.05	Total program cost (see instructions)	0	1,335,453	16.05
17.00	Primary payer amounts		215	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		158,773	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		315,268	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,335,238	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		128,585	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,463,823	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		1,463,823	26.00
26.01	Sequestration adjustment (see instructions)		29,276	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		1,337,668	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)		96,879	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: 14-1325 | Component CCN: 14-3445 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/24/2024 6:39 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)	4,702,914	4,702,914	4,702,914	4,702,914	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002233	0.006691	0.001740	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	10,502	31,467	8,183	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	158,562	56,225	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	169,064	87,692	8,183	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	5,159,235	5,159,235	5,159,235	5,159,235	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	5,987,543	5,987,543	5,987,543	5,987,543	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.032769	0.016997	0.001586	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	196,206	101,770	9,496	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	365,270	189,462	17,679	0	10.00
11.00	Total number of injections/infusions (from your records)	761	2,280	593	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	479.99	83.10	29.81	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	155	571	226	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)	74,398	47,450	6,737	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)		572,411	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)		128,585	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1325 Component CCN: 14-3445	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/24/2024 6:39 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,337,668	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)		1,337,668	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		96,879	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,434,547	7.00

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