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: 14-1318	Period: From 10/01/2022 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/20/2024 3:03 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/20/2024 Time: 3:03 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 HOLY FAMILY MED CTR (14-1318) 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	41,815	486,176	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	125,025	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		54,885		0	10.00
10.01	RURAL HEALTH CLINIC II	0		20,256		0	10.01
200.00	TOTAL	0	166,840	561,317	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: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/20/2024 3:03 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 WEST HARLEM AVENUE	PO Box:			1.00
2.00	City: MONMOUTH	State: IL	Zip Code: 61462	County: WARREN	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 HOLY FAMILY MED CTR	141318	99914	1	05/01/2002	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	OSF HOLY FAMILY SWING BEDS	14Z318	99914		05/01/2002	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	OSF HOLY FAMILY CLINICS	143461	99914		02/05/2003	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	OSF ROSEVILLE RHC	148621	99914		02/18/2021	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	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: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/20/2024 3:03 pm

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.	N			57.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/20/2024 3:03 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/20/2024 3:03 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: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/20/2024 3:03 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

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		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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)	N		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)			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.	Y	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: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/20/2024 3:03 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	7,091	0	10,333	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: 14-1318	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part I Date/Time Prepared: 2/20/2024 3:03 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	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/20/2024 3:03 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: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II Date/Time Prepared: 2/20/2024 3:03 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.	FORVIS		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: 14-1318	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part II Date/Time Prepared: 2/20/2024 3:03 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: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 2/20/2024 3:03 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	15	5,475	18,720.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		15	5,475	18,720.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		15	5,475	18,720.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		15				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: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/20/2024 3:03 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)	385	18	703			1.00
2.00	HMO and other (see instructions)	192	76				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	496	0	840			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		5	125			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	881	23	1,668			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)	881	23	1,668	0.00	104.79	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	5,924	8,659	30,424	0.00	42.40	26.00
26.01	RURAL HEALTH CLINIC II	587	523	2,588	0.00	3.94	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	151.13	27.00
28.00	Observation Bed Days		71	384			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: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/20/2024 3:03 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	130	6	231	1.00
2.00	HMO and other (see instructions)			51	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	130	6	231	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1318 | Component CCN: 14-3461 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/20/2024 3:03 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1000 W. HARLEM		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MONMOUTH		IL	61462	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	18:00	07:00	11.00

		1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?	N	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0 13.00

		Provider name	CCN
		1.00	2.00
14.00	RHC/FQHC name, CCN		14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		WARREN				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	18:00	07:00	18:00	07:00	18:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1318
Component CCN: 14-3461

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

Worksheet S-8
Date/Time Prepared:
2/20/2024 3:03 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	07:00	18:00	08:00	17:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1318 | Component CCN: 14-8621 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/20/2024 3:03 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			235 E. PENN AVENUE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ROSEVILLE		IL	61473	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	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.				N	0	13.00
				Provider name		CCN	
				1.00		2.00	
14.00	RHC/FQHC name, CCN						14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		WARREN				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	11:15	07:00	17:00	07:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1318
Component CCN: 14-8621

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

Worksheet S-8

Date/Time Prepared:
2/20/2024 3:03 pm

RHC II

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1318	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/20/2024 3:03 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)	0.267091	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,910,771	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	20,282,360	6.00
7.00	Medicaid cost (line 1 times line 6)	5,417,236	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	0	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)	0	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)	1,215,871	436,943	1,652,814	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	324,748	436,943	761,691	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)	324,748	436,943	761,691	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)	1,585,282	26.00
27.00	Medicare reimbursable bad debts (see instructions)	70,658	27.00
27.01	Medicare allowable bad debts (see instructions)	108,706	27.01
28.00	Non-Medicare bad debt amount (see instructions)	1,476,576	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	432,428	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,194,119	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,194,119	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1318	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/20/2024 3:03 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: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/20/2024 3:03 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		1,160,504	1,160,504	40,671	1,201,175	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		323,395	323,395	405,575	728,970	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	97,254	80,508	177,762	3,331,167	3,508,929	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,108,464	6,966,688	8,075,152	-1,015,442	7,059,710	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	673,643	673,643	-424,717	248,926	6.00
7.00	00700	OPERATION OF PLANT	315,595	1,010,385	1,325,980	-71,064	1,254,916	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	4,216	4,216	8.00
9.00	00900	HOUSEKEEPING	460,422	363,092	823,514	-155,192	668,322	9.00
10.00	01000	DIETARY	359,957	302,070	662,027	-96,756	565,271	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	141,438	37,384	178,822	-34,376	144,446	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,790	2,790	45,340	48,130	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	291,281	291,281	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,381,133	542,102	1,923,235	-390,142	1,533,093	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	524,154	883,725	1,407,879	-445,098	962,781	50.00
53.00	05300	ANESTHESIOLOGY	138,688	-134,901	3,787	-19,610	-15,823	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	702,159	306,425	1,008,584	97,179	1,105,763	54.00
56.00	05600	RADIOISOTOPE	35,236	44,589	79,825	-7,012	72,813	56.00
57.00	05700	CT SCAN	0	68,191	68,191	-22,274	45,917	57.00
58.00	05800	MRI	0	299,237	299,237	-1,743	297,494	58.00
60.00	06000	LABORATORY	703,156	913,665	1,616,821	-104,429	1,512,392	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	23,068	23,068	64.00
65.00	06500	RESPIRATORY THERAPY	151,055	73,796	224,851	-51,087	173,764	65.00
66.00	06600	PHYSICAL THERAPY	325,281	111,490	436,771	-93,853	342,918	66.00
67.00	06700	OCCUPATIONAL THERAPY	99,206	21,691	120,897	10,246	131,143	67.00
68.00	06800	SPEECH PATHOLOGY	1,179	306	1,485	954	2,439	68.00
69.00	06900	ELECTROCARDIOLOGY	366,815	143,963	510,778	-117,727	393,051	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	-33,789	-33,789	39,489	5,700	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	246,056	246,056	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	243,291	1,488,324	1,731,615	304,855	2,036,470	73.00
76.00	03950	DIABETIC SERVICES	20,907	8,774	29,681	-7,964	21,717	76.00
76.01	03020	WOUND CLINIC	72,948	784,243	857,191	-348,062	509,129	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
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	3,816,370	2,234,279	6,050,649	-1,032,389	5,018,260	88.00
88.01	08801	RURAL HEALTH CLINIC II	288,356	203,346	491,702	-63,237	428,465	88.01
91.00	09100	EMERGENCY	1,384,464	2,091,145	3,475,609	-337,899	3,137,710	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						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,737,528	20,971,060	33,708,588	24	33,708,612	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	201	25	226	-24	202	194.00
194.01	07951	RESEARCH	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	12,737,729	20,971,085	33,708,814	0	33,708,814	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/20/2024 3:03 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	169,020	1,370,195		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	512,552	1,241,522		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	39	3,508,968		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,314,138	5,745,572		5.00
6.00	00600	MAINTENANCE & REPAIRS	-11,465	237,461		6.00
7.00	00700	OPERATION OF PLANT	0	1,254,916		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,216		8.00
9.00	00900	HOUSEKEEPING	0	668,322		9.00
10.00	01000	DIETARY	0	565,271		10.00
11.00	01100	CAFETERIA	-74,262	-74,262		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	302,791	447,237		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-40	48,090		16.00
17.00	01700	SOCIAL SERVICE	-10,665	280,616		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-38,648	1,494,445		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	962,781		50.00
53.00	05300	ANESTHESIOLOGY	54,341	38,518		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-16,529	1,089,234		54.00
56.00	05600	RADIOISOTOPE	0	72,813		56.00
57.00	05700	CT SCAN	0	45,917		57.00
58.00	05800	MRI	0	297,494		58.00
60.00	06000	LABORATORY	-3,165	1,509,227		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400	INTRAVENOUS THERAPY	0	23,068		64.00
65.00	06500	RESPIRATORY THERAPY	0	173,764		65.00
66.00	06600	PHYSICAL THERAPY	1,842	344,760		66.00
67.00	06700	OCCUPATIONAL THERAPY	510	131,653		67.00
68.00	06800	SPEECH PATHOLOGY	6	2,445		68.00
69.00	06900	ELECTROCARDIOLOGY	0	393,051		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,700		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	246,056		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-420,783	1,615,687		73.00
76.00	03950	DIABETIC SERVICES	-250	21,467		76.00
76.01	03020	WOUND CLINIC	68,633	577,762		76.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
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	-330,719	4,687,541		88.00
88.01	08801	RURAL HEALTH CLINIC II	-42,363	386,102		88.01
91.00	09100	EMERGENCY	-1,309,527	1,828,183		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				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,462,820	31,245,792		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		192.00
194.00	07950	NONREIMBURSABLE COST CENTER	0	202		194.00
194.01	07951	RESEARCH	0	0		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,462,820	31,245,994		200.00

RECLASSIFICATIONS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/20/2024 3:03 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - MAINTENANCE COSTS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	356,118	1.00
2.00	LABORATORY	60.00	0	68,599	2.00
	0		0	424,717	
	B - DRUGS RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	24,664	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
	0		0	24,664	
	C - OTHER THERAPEUTIC SERVICES				
1.00	INTRAVENOUS THERAPY	64.00	23,068	0	1.00
	0		23,068	0	
	E - PREMIER CONTRACT ADMIN FEES RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	26,863	1.00
	TOTALS		0	26,863	
	F - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	26,024	1.00
	0		0	26,024	
	G - EMPLOYEE BENEFIT RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,285,670	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
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
	0		0	3,285,670	
	H - WOUND CLINIC IMPLANTS RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	321,589	1.00
	TOTALS		0	321,589	
	I - DEPRECIATION RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	21,621	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	398,601	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
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
	0		0	420,222	
	J - LAUNDRY RECLASS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	4,216	1.00
2.00		0.00	0	0	2.00
	0		0	4,216	

RECLASSIFICATIONS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/20/2024 3:03 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	K - MED SUPPLIES & IMPLANTABLE DEVICES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	14,187	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	246,056	2.00
	0		0	260,243	
	M - MINISTRY ALLOCATION RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	166,609	1.00
2.00	OPERATION OF PLANT	7.00	0	88,187	2.00
3.00	SOCIAL SERVICE	17.00	0	291,281	3.00
4.00	PHYSICAL THERAPY	66.00	0	18,415	4.00
5.00	OCCUPATIONAL THERAPY	67.00	0	5,097	5.00
6.00	SPEECH PATHOLOGY	68.00	0	63	6.00
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	38,487	7.00
	0		0	608,139	
	P - REHAB ADMINISTRATION				
1.00	OCCUPATIONAL THERAPY	67.00	20,557	3,925	1.00
2.00	SPEECH PATHOLOGY	68.00	998	190	2.00
	0		21,555	4,115	
	R - VACATION, PTO, REWARDS				
1.00	ADMINISTRATIVE & GENERAL	5.00	3,102	0	1.00
2.00	OPERATION OF PLANT	7.00	701	0	2.00
3.00	HOUSEKEEPING	9.00	1,011	0	3.00
4.00	DIETARY	10.00	679	0	4.00
5.00	NURSING ADMINISTRATION	13.00	267	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	2,647	0	6.00
7.00	OPERATING ROOM	50.00	1,754	0	7.00
8.00	ANESTHESIOLOGY	53.00	262	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	1,325	0	9.00
10.00	RADIOISOTOPE	56.00	67	0	10.00
11.00	LABORATORY	60.00	1,327	0	11.00
12.00	RESPIRATORY THERAPY	65.00	285	0	12.00
13.00	PHYSICAL THERAPY	66.00	614	0	13.00
14.00	OCCUPATIONAL THERAPY	67.00	187	0	14.00
15.00	SPEECH PATHOLOGY	68.00	2	0	15.00
16.00	ELECTROCARDIOLOGY	69.00	692	0	16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	459	0	17.00
18.00	DIABETIC SERVICES	76.00	39	0	18.00
19.00	WOUND CLINIC	76.01	138	0	19.00
20.00	RURAL HEALTH CLINIC	88.00	7,203	0	20.00
21.00	RURAL HEALTH CLINIC II	88.01	544	0	21.00
22.00	EMERGENCY	91.00	2,645	0	22.00
	0		25,950	0	
	S - SHORT TERM DISABILITY				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	881	1.00
2.00	HOUSEKEEPING	9.00	0	700	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	2,217	3.00
	0		0	3,798	
	T - RHC PROVIDER RECLASS				
1.00	RURAL HEALTH CLINIC II	88.01	18,229	0	1.00
	TOTALS		18,229	0	
	V - RETENTION BONUS				
1.00	ADMINISTRATIVE & GENERAL	5.00	6,445	0	1.00
2.00	OPERATION OF PLANT	7.00	1,835	0	2.00
3.00	HOUSEKEEPING	9.00	2,678	0	3.00
4.00	DIETARY	10.00	2,093	0	4.00
5.00	NURSING ADMINISTRATION	13.00	823	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	13,078	0	6.00
7.00	OPERATING ROOM	50.00	5,719	0	7.00
8.00	ANESTHESIOLOGY	53.00	807	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	4,083	0	9.00
10.00	RADIOISOTOPE	56.00	205	0	10.00
11.00	LABORATORY	60.00	4,089	0	11.00
12.00	RESPIRATORY THERAPY	65.00	3,550	0	12.00
13.00	PHYSICAL THERAPY	66.00	1,892	0	13.00
14.00	OCCUPATIONAL THERAPY	67.00	577	0	14.00
15.00	SPEECH PATHOLOGY	68.00	7	0	15.00
16.00	ELECTROCARDIOLOGY	69.00	3,320	0	16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	1,415	0	17.00
18.00	DIABETIC SERVICES	76.00	122	0	18.00
19.00	WOUND CLINIC	76.01	424	0	19.00
20.00	RURAL HEALTH CLINIC	88.00	22,194	0	20.00
21.00	RURAL HEALTH CLINIC II	88.01	1,677	0	21.00
22.00	EMERGENCY	91.00	20,220	0	22.00

RECLASSIFICATIONS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/20/2024 3:03 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
23.00	NONREIMBURSABLE COST CENTER	194.00	1	0		23.00
	0		97,254	0		
	X - MINISTRY MEDICAL RECORDS					
1.00	MEDICAL RECORDS & LIBRARY	16.00	0	45,340		1.00
	0		0	45,340		
	Z - REGIONAL ADMIN COSTS					
1.00	RURAL HEALTH CLINIC	88.00	0	14,208		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	1,155		2.00
	TOTALS		0	15,363		
500.00	Grand Total: Increases		186,056	5,470,963		500.00

RECLASSIFICATIONS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/20/2024 3:03 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - MAINTENANCE COSTS					
1.00	MAINTENANCE & REPAIRS	6.00	0	424,717	0	1.00
2.00		0.00	0	0	0	2.00
	0		0	424,717		
	B - DRUGS RECLASS					
1.00	OPERATING ROOM	50.00	0	12,015	0	1.00
2.00	CT SCAN	57.00	0	6,752	0	2.00
3.00	MRI	58.00	0	1,743	0	3.00
4.00	LABORATORY	60.00	0	84	0	4.00
5.00	WOUND CLINIC	76.01	0	4,070	0	5.00
	0		0	24,664		
	C - OTHER THERAPEUTIC SERVICES					
1.00	ADULTS & PEDIATRICS	30.00	23,068	0	0	1.00
	0		23,068	0		
	E - PREMIER CONTRACT ADMIN FEES RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	26,863	0	1.00
	TOTALS		0	26,863		
	F - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	26,024	12	1.00
	0		0	26,024		
	G - EMPLOYEE BENEFIT RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	267,187	0	1.00
2.00	OPERATION OF PLANT	7.00	0	88,705	0	2.00
3.00	HOUSEKEEPING	9.00	0	158,124	0	3.00
4.00	DIETARY	10.00	0	93,286	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	35,466	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	349,082	0	6.00
7.00	OPERATING ROOM	50.00	0	129,395	0	7.00
8.00	ANESTHESIOLOGY	53.00	0	17,752	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	181,673	0	9.00
10.00	RADIOISOTOPE	56.00	0	2,746	0	10.00
11.00	LABORATORY	60.00	0	163,959	0	11.00
12.00	RESPIRATORY THERAPY	65.00	0	49,124	0	12.00
13.00	PHYSICAL THERAPY	66.00	0	84,934	0	13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	20,097	0	14.00
15.00	SPEECH PATHOLOGY	68.00	0	306	0	15.00
16.00	ELECTROCARDIOLOGY	69.00	0	114,985	0	16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	59,470	0	17.00
18.00	DIABETIC SERVICES	76.00	0	8,125	0	18.00
19.00	WOUND CLINIC	76.01	0	22,965	0	19.00
20.00	RURAL HEALTH CLINIC	88.00	0	1,044,027	0	20.00
21.00	RURAL HEALTH CLINIC II	88.01	0	82,100	0	21.00
22.00	EMERGENCY	91.00	0	312,137	0	22.00
23.00	NONREIMBURSABLE COST CENTER	194.00	0	25	0	23.00
	0		0	3,285,670		
	H - WOUND CLINIC IMPLANTS RECLASS					
1.00	WOUND CLINIC	76.01	0	321,589	0	1.00
	TOTALS		0	321,589		
	I - DEPRECIATION RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	35,065	9	1.00
2.00	OPERATION OF PLANT	7.00	0	72,977	9	2.00
3.00	HOUSEKEEPING	9.00	0	615	0	3.00
4.00	DIETARY	10.00	0	6,242	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	33,677	0	5.00
6.00	OPERATING ROOM	50.00	0	50,153	0	6.00
7.00	ANESTHESIOLOGY	53.00	0	2,927	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	82,674	0	8.00
9.00	RADIOISOTOPE	56.00	0	4,538	0	9.00
10.00	CT SCAN	57.00	0	15,522	0	10.00
11.00	LABORATORY	60.00	0	11,758	0	11.00
12.00	RESPIRATORY THERAPY	65.00	0	5,798	0	12.00
13.00	PHYSICAL THERAPY	66.00	0	4,170	0	13.00
14.00	ELECTROCARDIOLOGY	69.00	0	5,181	0	14.00
15.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,561	0	15.00
16.00	DRUGS CHARGED TO PATIENTS	73.00	0	22,289	0	16.00
17.00	RURAL HEALTH CLINIC	88.00	0	13,738	0	17.00
18.00	RURAL HEALTH CLINIC II	88.01	0	2,742	0	18.00
19.00	EMERGENCY	91.00	0	48,595	0	19.00
	0		0	420,222		
	J - LAUNDRY RECLASS					
1.00	LABORATORY	60.00	0	2,643	0	1.00
2.00	ELECTROCARDIOLOGY	69.00	0	1,573	0	2.00
	0		0	4,216		

RECLASSIFICATIONS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/20/2024 3:03 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	K - MED SUPPLIES & IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	260,243	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	260,243			
	M - MINISTRY ALLOCATION RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	608,139	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	608,139			
	P - REHAB ADMINISTRATION						
1.00	PHYSICAL THERAPY	66.00	21,555	4,115	0		1.00
2.00		0.00	0	0	0		2.00
	0		21,555	4,115			
	R - VACATION, PTO, REWARDS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	23,858	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,008	0		2.00
3.00	OPERATION OF PLANT	7.00	0	105	0		3.00
4.00	HOUSEKEEPING	9.00	0	142	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	40	0		5.00
6.00	OPERATING ROOM	50.00	0	765	0		6.00
7.00	EMERGENCY	91.00	0	32	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
	0		0	25,950			
	S - SHORT TERM DISABILITY						
1.00	ADMINISTRATIVE & GENERAL	5.00	881	0	0		1.00
2.00	HOUSEKEEPING	9.00	700	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	2,217	0	0		3.00
	0		3,798	0			
	T - RHC PROVIDER RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	18,229	0	0		1.00
	TOTALS		18,229	0			
	V - RETENTION BONUS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	97,254	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
	0		97,254	0			

RECLASSIFICATIONS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/20/2024 3:03 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	X - MINISTRY MEDICAL RECORDS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	45,340	0		1.00
	0		0	45,340			
	Z - REGIONAL ADMIN COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15,363	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	15,363			
500.00	Grand Total: Decreases		163,904	5,493,115			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 2/20/2024 3:03 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	325,000	0	0	0	0	1.00
2.00	Land Improvements	369,733	115,192	0	115,192	0	2.00
3.00	Buildings and Fixtures	20,716,827	6,370,589	0	6,370,589	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	15,762,640	0	0	0	5,549,449	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,174,200	6,485,781	0	6,485,781	5,549,449	8.00
9.00	Reconciling Items	6,340,660	-5,974,388	0	-5,974,388	0	9.00
10.00	Total (line 8 minus line 9)	30,833,540	12,460,169	0	12,460,169	5,549,449	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	325,000	0	1.00
2.00	Land Improvements	484,925	0	2.00
3.00	Buildings and Fixtures	27,087,416	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	10,213,191	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	38,110,532	0	8.00
9.00	Reconciling Items	366,272	0	9.00
10.00	Total (line 8 minus line 9)	37,744,260	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part II Date/Time Prepared: 2/20/2024 3:03 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	1,160,504	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	323,395	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,483,899	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	1,160,504		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	323,395		2.00
3.00	Total (sum of lines 1-2)	0	1,483,899		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part III | Date/Time Prepared: 2/20/2024 3:03 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	27,897,341	0	27,897,341	0.732011	19,050	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,213,191	0	10,213,191	0.267989	6,974	2.00
3.00	Total (sum of lines 1-2)	38,110,532	0	38,110,532	1.000000	26,024	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	19,050	1,351,145	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	6,974	1,234,548	0	2.00
3.00	Total (sum of lines 1-2)	0	0	26,024	2,585,693	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	19,050	0	0	1,370,195	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,974	0	0	1,241,522	2.00
3.00	Total (sum of lines 1-2)	0	26,024	0	0	2,611,717	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/20/2024 3:03 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)	B	0	ADMINISTRATIVE & GENERAL	5.00	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	-11,229	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,178,420			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	-135,613			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-74,262	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	B	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	-40	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)	B	-5,790	ADMINISTRATIVE & GENERAL	5.00	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	A	343,026	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	164,292	CAP REL COSTS-MVBLE EQUIP	2.00	9	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: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/20/2024 3:03 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		0		0.00	0	32.00
33.00	ADVERTISING EXPENSE	A	-200	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	LOBBYING	A	-11,373	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	PROVIDER TAX IDPA	A	-1,101,340	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISC. INCOME	B	-250	DIABETIC SERVICES	76.00	0	33.03
33.04	340B EXPENSE	A	-422,525	DRUGS CHARGED TO PATIENTS	73.00	0	33.04
33.05	CRNA BENEFITS	A	-17,781	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.05
33.06	DEFINED BENEFIT PENSION	A	17,820	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	MEDICAL DIRECTOR FEE	B	-13,700	RURAL HEALTH CLINIC	88.00	0	33.07
33.08	RHC MISC INCOME	B	-12,000	RURAL HEALTH CLINIC II	88.01	0	33.08
33.09	GUILD ADJUSTMENT	A	3,077	EMERGENCY	91.00	0	33.09
33.10	MALPRACTICE EXPENSE	A	-6,512	ADMINISTRATIVE & GENERAL	5.00	0	33.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,462,820				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: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/20/2024 3:03 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	140,436	298,031	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	348,260	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HO POOLED - ADMIN & GENERAL	2,329,075	3,268,972	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	MINISTRY ALLOCATION	166,609	166,609	3.01
3.02	6.00	MAINTENANCE & REPAIRS	MINISTRY ALLOCATION	177	177	3.02
3.03	7.00	OPERATION OF PLANT	MINISTRY ALLOCATION	88,187	88,187	3.03
3.04	30.00	ADULTS & PEDIATRICS	MINISTRY ALLOCATION	26,712	0	3.04
3.05	66.00	PHYSICAL THERAPY	MINISTRY ALLOCATION	20,257	18,415	3.05
3.06	67.00	OCCUPATIONAL THERAPY	MINISTRY ALLOCATION	5,607	5,097	3.06
3.07	68.00	SPEECH PATHOLOGY	MINISTRY ALLOCATION	69	63	3.07
3.08	73.00	DRUGS CHARGED TO PATIENTS	MINISTRY ALLOCATION	38,487	38,487	3.08
3.09	54.00	RADIOLOGY-DIAGNOSTIC	MINISTRY ALLOCATION	253	253	3.09
3.10	60.00	LABORATORY	MINISTRY ALLOCATION	49	49	3.10
4.00	13.00	NURSING ADMINISTRATION	HO FUNCTIONAL - NURSING ADMI	302,791	0	4.00
4.01	73.00	DRUGS CHARGED TO PATIENTS	HO FUNCTIONAL - NURSING ADMI	103,736	103,736	4.01
4.02	17.00	SOCIAL SERVICE	HO FUNCTIONAL - SOCIAL SERVI	280,616	291,281	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	HO FUNCTIONAL - ADMIN & GEN	1,909,248	1,147,100	4.03
4.04	73.00	DRUGS CHARGED TO PATIENTS	HO FUNCTIONAL - ADMIN & GEN	1,742	0	4.04
4.05	54.00	RADIOLOGY-DIAGNOSTIC	SFI EQUIPMENT RENTAL	5,759	5,856	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	SFI CVO	25,199	25,144	4.06
4.07	6.00	MAINTENANCE & REPAIRS	SFI HEALTHCARE TECHNOLOGY SV	237,005	248,470	4.07
4.08	54.00	RADIOLOGY-DIAGNOSTIC	SFI HEALTHCARE TECHNOLOGY SV	339,679	356,111	4.08
4.09	60.00	LABORATORY	SFI HEALTHCARE TECHNOLOGY SV	65,432	68,597	4.09
4.10	30.00	ADULTS & PEDIATRICS	PURCH SVCS-ST GABRIEL	225,423	225,954	4.10
4.11	1.00	CAP REL COSTS-BLDG & FIXT	OSFMG MINISTRY ALLOCATION	694	17,105	4.11
4.12	30.00	ADULTS & PEDIATRICS	OSFMG MINISTRY ALLOCATION	4,159	15,911	4.12
4.13	53.00	ANESTHESIOLOGY	OSFMG MINISTRY ALLOCATION	447	7,019	4.13
4.14	88.00	RURAL HEALTH CLINIC	OSFMG MINISTRY ALLOCATION	406,428	723,447	4.14
4.15	88.01	RURAL HEALTH CLINIC II	OSFMG MINISTRY ALLOCATION	40,003	70,366	4.15
4.16	91.00	EMERGENCY	OSFMG MINISTRY ALLOCATION	17,185	74,900	4.16
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,129,724	7,265,337	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	OSF HEALTHCARE SYSTEM	100.00		0.00	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: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/20/2024 3:03 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	-157,595	9		1.00
2.00	348,260	9		2.00
3.00	-939,897	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	26,712	0		3.04
3.05	1,842	0		3.05
3.06	510	0		3.06
3.07	6	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
4.00	302,791	0		4.00
4.01	0	0		4.01
4.02	-10,665	0		4.02
4.03	762,148	0		4.03
4.04	1,742	0		4.04
4.05	-97	0		4.05
4.06	55	0		4.06
4.07	-11,465	0		4.07
4.08	-16,432	0		4.08
4.09	-3,165	0		4.09
4.10	-531	0		4.10
4.11	-16,411	9		4.11
4.12	-11,752	0		4.12
4.13	-6,572	0		4.13
4.14	-317,019	0		4.14
4.15	-30,363	0		4.15
4.16	-57,715	0		4.16
5.00	-135,613			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			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: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 2/20/2024 3:03 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	53,077	53,077	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	-60,913	-60,913	0	0	0	2.00
3.00	53.00	DR. K	25,000	0	25,000	0	0	3.00
4.00	60.00	LABORATORY	14,400	0	14,400	0	0	4.00
5.00	76.01	WOUND CLINIC	-68,633	-68,633	0	0	0	5.00
6.00	91.00	EMERGENCY	1,513,373	1,254,889	258,484	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			1,476,304	1,178,420	297,884		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	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	53.00	DR. K	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	76.01	WOUND CLINIC	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	53,077		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	-60,913		2.00
3.00	53.00	DR. K	0	0	0	0		3.00
4.00	60.00	LABORATORY	0	0	0	0		4.00
5.00	76.01	WOUND CLINIC	0	0	0	-68,633		5.00
6.00	91.00	EMERGENCY	0	0	0	1,254,889		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,178,420		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1318	Period: From 10/01/2022 To 09/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/20/2024 3:03 pm

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					7	1.00
2.00	Line 1 multiplied by 15 hours per week					105	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.62	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	175.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	95.15	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	47.58	47.58	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					16,699	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					16,699	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					16,699	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					16,699	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/20/2024 3:03 pm

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	95.15	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	16,699		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	16,699		63.00
64.00	Total cost of outside supplier services (from your records)	14,965		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/20/2024 3:03 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	1,370,195	1,370,195				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,241,522		1,241,522			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,508,968	0	0	3,508,968		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,745,572	227,911	206,506	308,681	6,488,670	5.00
6.00	00600	MAINTENANCE & REPAIRS	237,461	0	0	0	237,461	6.00
7.00	00700	OPERATION OF PLANT	1,254,916	169,123	153,241	87,906	1,665,186	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,216	0	0	0	4,216	8.00
9.00	00900	HOUSEKEEPING	668,322	15,396	13,950	128,049	825,717	9.00
10.00	01000	DIETARY	565,271	86,677	78,537	100,229	830,714	10.00
11.00	01100	CAFETERIA	-74,262	0	0	0	-74,262	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	447,237	0	0	39,383	486,620	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	48,090	3,941	3,571	0	55,602	16.00
17.00	01700	SOCIAL SERVICE	280,616	0	0	0	280,616	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,494,445	134,166	121,567	378,992	2,129,170	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	962,781	95,058	86,131	146,899	1,290,869	50.00
53.00	05300	ANESTHESIOLOGY	38,518	3,035	2,750	21,786	66,089	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,089,234	58,301	52,826	195,514	1,395,875	54.00
56.00	05600	RADIOISOTOPE	72,813	0	0	9,812	82,625	56.00
57.00	05700	CT SCAN	45,917	0	0	0	45,917	57.00
58.00	05800	MRI	297,494	0	0	0	297,494	58.00
60.00	06000	LABORATORY	1,509,227	24,960	22,616	195,792	1,752,595	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	23,068	0	0	6,374	29,442	64.00
65.00	06500	RESPIRATORY THERAPY	173,764	3,941	3,571	42,799	224,075	65.00
66.00	06600	PHYSICAL THERAPY	344,760	58,341	52,862	84,618	540,581	66.00
67.00	06700	OCCUPATIONAL THERAPY	131,653	3,691	3,345	33,304	171,993	67.00
68.00	06800	SPEECH PATHOLOGY	2,445	460	417	604	3,926	68.00
69.00	06900	ELECTROCARDIOLOGY	393,051	31,410	28,460	102,467	555,388	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,700	38,701	35,067	0	79,468	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	246,056	0	0	0	246,056	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,615,687	17,406	15,772	67,744	1,716,609	73.00
76.00	03950	DIABETIC SERVICES	21,467	13,846	12,546	5,821	53,680	76.00
76.01	03020	WOUND CLINIC	577,762	7,291	6,606	20,312	611,971	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
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	4,687,541	205,788	186,463	1,057,625	6,137,417	88.00
88.01	08801	RURAL HEALTH CLINIC II	386,102	35,325	32,008	85,329	538,764	88.01
91.00	09100	EMERGENCY	1,828,183	78,689	71,300	388,872	2,367,044	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						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,245,792	1,313,457	1,190,112	3,508,912	31,137,588	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	56,738	51,410	0	108,148	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	202	0	0	56	258	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)	31,245,994	1,370,195	1,241,522	3,508,968	31,245,994	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/20/2024 3:03 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,488,670					5.00
6.00	00600	MAINTENANCE & REPAIRS	62,050	299,511				6.00
7.00	00700	OPERATION OF PLANT	435,125	44,345	2,144,656			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,102	0	0	5,318		8.00
9.00	00900	HOUSEKEEPING	215,766	4,037	33,930	0	1,079,450	9.00
10.00	01000	DIETARY	217,071	22,727	191,018	0	97,689	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	127,157	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,529	1,033	8,685	0	4,442	16.00
17.00	01700	SOCIAL SERVICE	73,327	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	556,367	35,179	295,676	1,539	151,212	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	337,313	24,925	209,489	636	107,135	50.00
53.00	05300	ANESTHESIOLOGY	17,270	796	6,688	0	3,420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	364,752	15,287	128,484	1,234	65,708	54.00
56.00	05600	RADIOISOTOPE	21,590	0	0	0	0	56.00
57.00	05700	CT SCAN	11,998	0	0	0	0	57.00
58.00	05800	MRI	77,737	0	0	0	0	58.00
60.00	06000	LABORATORY	457,965	6,545	55,007	9	28,131	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	7,693	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	58,552	1,033	8,685	0	4,442	65.00
66.00	06600	PHYSICAL THERAPY	141,258	15,297	128,571	146	65,753	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,943	968	8,135	56	4,160	67.00
68.00	06800	SPEECH PATHOLOGY	1,026	121	1,013	3	518	68.00
69.00	06900	ELECTROCARDIOLOGY	145,127	8,236	69,222	94	35,401	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,766	10,148	85,289	0	43,618	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,296	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	448,562	4,564	38,360	0	19,618	73.00
76.00	03950	DIABETIC SERVICES	14,027	3,631	30,514	0	15,605	76.00
76.01	03020	WOUND CLINIC	159,912	1,912	16,068	0	8,217	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
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	1,603,754	53,955	453,518	52	231,935	88.00
88.01	08801	RURAL HEALTH CLINIC II	140,783	9,262	77,849	0	39,813	88.01
91.00	09100	EMERGENCY	618,525	20,633	173,416	1,493	88,687	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						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,460,343	284,634	2,019,617	5,262	1,015,504	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	28,260	14,877	125,039	56	63,946	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	67	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)	6,488,670	299,511	2,144,656	5,318	1,079,450	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/20/2024 3:03 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,359,219					10.00
11.00	01100	CAFETERIA	918,011	843,749				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	9,958	0	623,735		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	369,530	111,915	0	292,699	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,512	46,371	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	3,641	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	66,064	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	2,824	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	76,096	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	1,932	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	15,308	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	18,801	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,769	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	223	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	34,853	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,349	0	42,804	0	73.00
76.00	03950	DIABETIC SERVICES	0	1,784	0	4,757	0	76.00
76.01	03020	WOUND CLINIC	0	5,425	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
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	315,088	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	17,166	108,348	0	283,475	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						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,359,219	843,749	0	623,735	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	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	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,359,219	843,749	0	623,735	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/20/2024 3:03 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	84,291				16.00
17.00	01700	SOCIAL SERVICE	0	0	353,943			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,879	353,943	4,300,109	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	9,078	0	2,080,328	0	50.00
53.00	05300	ANESTHESIOLOGY	0	1,326	0	99,230	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,770	0	2,044,174	0	54.00
56.00	05600	RADIOISOTOPE	0	777	0	107,816	0	56.00
57.00	05700	CT SCAN	0	11,026	0	68,941	0	57.00
58.00	05800	MRI	0	2,490	0	377,721	0	58.00
60.00	06000	LABORATORY	0	15,286	0	2,391,634	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	341	0	39,408	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,125	0	313,220	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,308	0	911,715	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	502	0	239,526	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	24	0	6,854	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,222	0	851,543	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	121	0	239,410	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,677	0	312,029	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,626	0	2,295,492	0	73.00
76.00	03950	DIABETIC SERVICES	0	6	0	124,004	0	76.00
76.01	03020	WOUND CLINIC	0	1,137	0	804,642	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
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	6,808	0	8,802,527	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	605	0	807,076	0	88.01
91.00	09100	EMERGENCY	0	9,157	0	3,687,944	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	84,291	353,943	30,905,343	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	340,326	0	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	0	0	0	325	0	194.00
194.01	07951	RESEARCH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	84,291	353,943	31,245,994	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/20/2024 3:03 pm

		Cost Center Description	Total
			26.00
		GENERAL SERVICE COST CENTERS	
1.00	00100	CAP REL COSTS-BLDG & FIXT	
2.00	00200	CAP REL COSTS-MVBLE EQUIP	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	
5.00	00500	ADMINISTRATIVE & GENERAL	
6.00	00600	MAINTENANCE & REPAIRS	
7.00	00700	OPERATION OF PLANT	
8.00	00800	LAUNDRY & LINEN SERVICE	
9.00	00900	HOUSEKEEPING	
10.00	01000	DIETARY	
11.00	01100	CAFETERIA	
12.00	01200	MAINTENANCE OF PERSONNEL	
13.00	01300	NURSING ADMINISTRATION	
14.00	01400	CENTRAL SERVICES & SUPPLY	
15.00	01500	PHARMACY	
16.00	01600	MEDICAL RECORDS & LIBRARY	
17.00	01700	SOCIAL SERVICE	
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	4,300,109
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	2,080,328
53.00	05300	ANESTHESIOLOGY	99,230
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,044,174
56.00	05600	RADIOISOTOPE	107,816
57.00	05700	CT SCAN	68,941
58.00	05800	MRI	377,721
60.00	06000	LABORATORY	2,391,634
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0
64.00	06400	INTRAVENOUS THERAPY	39,408
65.00	06500	RESPIRATORY THERAPY	313,220
66.00	06600	PHYSICAL THERAPY	911,715
67.00	06700	OCCUPATIONAL THERAPY	239,526
68.00	06800	SPEECH PATHOLOGY	6,854
69.00	06900	ELECTROCARDIOLOGY	851,543
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	239,410
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	312,029
73.00	07300	DRUGS CHARGED TO PATIENTS	2,295,492
76.00	03950	DIABETIC SERVICES	124,004
76.01	03020	WOUND CLINIC	804,642
76.97	07697	CARDIAC REHABILITATION	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0
76.99	07699	LITHOTRIPSY	0
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0
		OUTPATIENT SERVICE COST CENTERS	
88.00	08800	RURAL HEALTH CLINIC	8,802,527
88.01	08801	RURAL HEALTH CLINIC II	807,076
91.00	09100	EMERGENCY	3,687,944
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	
		OTHER REIMBURSABLE COST CENTERS	
102.00	10200	OPIOID TREATMENT PROGRAM	0
		SPECIAL PURPOSE COST CENTERS	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,905,343
		NONREIMBURSABLE COST CENTERS	
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0
192.00	19200	PHYSICIANS PRIVATE OFFICES	340,326
194.00	07950	NONREIMBURSABLE COST CENTER	325
194.01	07951	RESEARCH	0
200.00		Cross Foot Adjustments	0
201.00		Negative Cost Centers	0
202.00		TOTAL (sum lines 118 through 201)	31,245,994

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/20/2024 3:03 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,600	227,911	206,506	438,017	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	7,967	0	0	7,967	0	6.00
7.00	00700	OPERATION OF PLANT	22,538	169,123	153,241	344,902	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	15,396	13,950	29,346	0	9.00
10.00	01000	DIETARY	0	86,677	78,537	165,214	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,941	3,571	7,512	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	134,166	121,567	255,733	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	95,058	86,131	181,189	0	50.00
53.00	05300	ANESTHESIOLOGY	2,102	3,035	2,750	7,887	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	58,301	52,826	111,127	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	24,960	22,616	47,576	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,327	3,941	3,571	12,839	0	65.00
66.00	06600	PHYSICAL THERAPY	0	58,341	52,862	111,203	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,691	3,345	7,036	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	460	417	877	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,941	31,410	28,460	61,811	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	38,701	35,067	73,768	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	17,406	15,772	33,178	0	73.00
76.00	03950	DIABETIC SERVICES	0	13,846	12,546	26,392	0	76.00
76.01	03020	WOUND CLINIC	0	7,291	6,606	13,897	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
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	205,788	186,463	392,251	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	35,325	32,008	67,333	0	88.01
91.00	09100	EMERGENCY	0	78,689	71,300	149,989	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,475	1,313,457	1,190,112	2,547,044	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	56,738	51,410	108,148	0	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	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)	43,475	1,370,195	1,241,522	2,655,192	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/20/2024 3:03 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	438,017					5.00
6.00	00600	MAINTENANCE & REPAIRS	4,189	12,156				6.00
7.00	00700	OPERATION OF PLANT	29,374	1,800	376,076			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	74	0	0	74		8.00
9.00	00900	HOUSEKEEPING	14,566	164	5,950	0	50,026	9.00
10.00	01000	DIETARY	14,654	922	33,496	0	4,527	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	8,584	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	981	42	1,523	0	206	16.00
17.00	01700	SOCIAL SERVICE	4,950	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,559	1,428	51,848	21	7,008	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,771	1,012	36,735	9	4,965	50.00
53.00	05300	ANESTHESIOLOGY	1,166	32	1,173	0	159	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,623	620	22,530	17	3,045	54.00
56.00	05600	RADIOISOTOPE	1,458	0	0	0	0	56.00
57.00	05700	CT SCAN	810	0	0	0	0	57.00
58.00	05800	MRI	5,248	0	0	0	0	58.00
60.00	06000	LABORATORY	30,916	266	9,646	0	1,304	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	519	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,953	42	1,523	0	206	65.00
66.00	06600	PHYSICAL THERAPY	9,536	621	22,546	2	3,047	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,034	39	1,427	1	193	67.00
68.00	06800	SPEECH PATHOLOGY	69	5	178	0	24	68.00
69.00	06900	ELECTROCARDIOLOGY	9,797	334	12,138	1	1,641	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,402	412	14,956	0	2,021	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,340	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,281	185	6,727	0	909	73.00
76.00	03950	DIABETIC SERVICES	947	147	5,351	0	723	76.00
76.01	03020	WOUND CLINIC	10,795	78	2,818	0	381	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
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	108,249	2,190	79,525	1	10,748	88.00
88.01	08801	RURAL HEALTH CLINIC II	9,504	376	13,651	0	1,845	88.01
91.00	09100	EMERGENCY	41,755	837	30,409	21	4,110	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						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	436,104	11,552	354,150	73	47,062	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,908	604	21,926	1	2,964	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	5	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)	438,017	12,156	376,076	74	50,026	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/20/2024 3:03 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	218,813					10.00
11.00	01100	CAFETERIA	147,786	135,831				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	1,603	0	10,187		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	59,488	18,017	0	4,780	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,776	7,465	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	586	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,635	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	455	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	12,250	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	311	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,464	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,027	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,412	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	36	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,611	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,632	0	699	0	73.00
76.00	03950	DIABETIC SERVICES	0	287	0	78	0	76.00
76.01	03020	WOUND CLINIC	0	873	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
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	50,725	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	2,763	17,442	0	4,630	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						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	218,813	135,831	0	10,187	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	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	0	11,955	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	218,813	147,786	0	10,187	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/20/2024 3:03 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,264				16.00
17.00	01700	SOCIAL SERVICE	0	0	4,950			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	352	4,950	441,184	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,110	0	264,032	0	50.00
53.00	05300	ANESTHESIOLOGY	0	162	0	11,165	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	828	0	173,425	0	54.00
56.00	05600	RADIOISOTOPE	0	95	0	2,008	0	56.00
57.00	05700	CT SCAN	0	1,348	0	2,158	0	57.00
58.00	05800	MRI	0	304	0	5,552	0	58.00
60.00	06000	LABORATORY	0	1,826	0	103,784	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	42	0	872	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	138	0	21,165	0	65.00
66.00	06600	PHYSICAL THERAPY	0	160	0	150,142	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	61	0	13,203	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3	0	1,192	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	394	0	91,727	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15	0	92,574	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	205	0	4,545	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,055	0	75,666	0	73.00
76.00	03950	DIABETIC SERVICES	0	1	0	33,926	0	76.00
76.01	03020	WOUND CLINIC	0	139	0	28,981	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
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	832	0	644,521	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	74	0	92,783	0	88.01
91.00	09100	EMERGENCY	0	1,120	0	253,076	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	10,264	4,950	2,507,681	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	135,551	0	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	0	0	0	5	0	194.00
194.01	07951	RESEARCH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	11,955	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	10,264	4,950	2,655,192	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/20/2024 3:03 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	441,184		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	264,032		50.00
53.00	05300	ANESTHESIOLOGY	11,165		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	173,425		54.00
56.00	05600	RADIOISOTOPE	2,008		56.00
57.00	05700	CT SCAN	2,158		57.00
58.00	05800	MRI	5,552		58.00
60.00	06000	LABORATORY	103,784		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
64.00	06400	INTRAVENOUS THERAPY	872		64.00
65.00	06500	RESPIRATORY THERAPY	21,165		65.00
66.00	06600	PHYSICAL THERAPY	150,142		66.00
67.00	06700	OCCUPATIONAL THERAPY	13,203		67.00
68.00	06800	SPEECH PATHOLOGY	1,192		68.00
69.00	06900	ELECTROCARDIOLOGY	91,727		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	92,574		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,545		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	75,666		73.00
76.00	03950	DIABETIC SERVICES	33,926		76.00
76.01	03020	WOUND CLINIC	28,981		76.01
76.97	07697	CARDIAC REHABILITATION	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		76.98
76.99	07699	LITHOTRIPSY	0		76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		78.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	644,521		88.00
88.01	08801	RURAL HEALTH CLINIC II	92,783		88.01
91.00	09100	EMERGENCY	253,076		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,507,681		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	135,551		192.00
194.00	07950	NONREIMBURSABLE COST CENTER	5		194.00
194.01	07951	RESEARCH	0		194.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	11,955		201.00
202.00		TOTAL (sum lines 118 through 201)	2,655,192		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/20/2024 3:03 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	104,302					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		104,302				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	12,698,957			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,349	17,349	1,117,119	-6,488,670	24,831,586	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	237,461	6.00
7.00	00700	OPERATION OF PLANT	12,874	12,874	318,131	0	1,665,186	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	4,216	8.00
9.00	00900	HOUSEKEEPING	1,172	1,172	463,411	0	825,717	9.00
10.00	01000	DIETARY	6,598	6,598	362,729	0	830,714	10.00
11.00	01100	CAFETERIA	0	0	0	74,262	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	142,528	0	486,620	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	300	300	0	0	55,602	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	280,616	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,213	10,213	1,371,573	0	2,129,170	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,236	7,236	531,627	0	1,290,869	50.00
53.00	05300	ANESTHESIOLOGY	231	231	78,844	0	66,089	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,438	4,438	707,567	0	1,395,875	54.00
56.00	05600	RADIOISOTOPE	0	0	35,508	0	82,625	56.00
57.00	05700	CT SCAN	0	0	0	0	45,917	57.00
58.00	05800	MRI	0	0	0	0	297,494	58.00
60.00	06000	LABORATORY	1,900	1,900	708,572	0	1,752,595	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	23,068	0	29,442	64.00
65.00	06500	RESPIRATORY THERAPY	300	300	154,890	0	224,075	65.00
66.00	06600	PHYSICAL THERAPY	4,441	4,441	306,232	0	540,581	66.00
67.00	06700	OCCUPATIONAL THERAPY	281	281	120,527	0	171,993	67.00
68.00	06800	SPEECH PATHOLOGY	35	35	2,186	0	3,926	68.00
69.00	06900	ELECTROCARDIOLOGY	2,391	2,391	370,827	0	555,388	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,946	2,946	0	0	79,468	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	246,056	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,325	1,325	245,165	0	1,716,609	73.00
76.00	03950	DIABETIC SERVICES	1,054	1,054	21,068	0	53,680	76.00
76.01	03020	WOUND CLINIC	555	555	73,510	0	611,971	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
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	15,665	15,665	3,827,538	0	6,137,417	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,689	2,689	308,806	0	538,764	88.01
91.00	09100	EMERGENCY	5,990	5,990	1,407,329	0	2,367,044	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						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,983	99,983	12,698,755	-6,414,408	24,723,180	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	4,319	4,319	0	0	108,148	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	0	0	202	0	258	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)	1,370,195	1,241,522	3,508,968		6,488,670	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.136805	11.903147	0.276319		0.261307	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		438,017	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.017640	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/20/2024 3:03 pm

	Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/20/2024 3:03 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	86,953					6.00
7.00	00700	OPERATION OF PLANT	12,874	74,079				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	101,987			8.00
9.00	00900	HOUSEKEEPING	1,172	1,172	0	72,907		9.00
10.00	01000	DIETARY	6,598	6,598	0	6,598	47,350	10.00
11.00	01100	CAFETERIA	0	0	0	0	31,980	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	300	300	0	300	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	10,213	10,213	29,491	10,213	12,873	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,236	7,236	12,203	7,236	1,899	50.00
53.00	05300	ANESTHESIOLOGY	231	231	0	231	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,438	4,438	23,673	4,438	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,900	1,900	174	1,900	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	300	300	0	300	0	65.00
66.00	06600	PHYSICAL THERAPY	4,441	4,441	2,794	4,441	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	281	281	1,073	281	0	67.00
68.00	06800	SPEECH PATHOLOGY	35	35	52	35	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,391	2,391	1,806	2,391	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,946	2,946	0	2,946	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	1,325	1,325	0	1,325	0	73.00
76.00	03950	DIABETIC SERVICES	1,054	1,054	0	1,054	0	76.00
76.01	03020	WOUND CLINIC	555	555	0	555	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
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	15,665	15,665	1,006	15,665	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,689	2,689	0	2,689	0	88.01
91.00	09100	EMERGENCY	5,990	5,990	28,639	5,990	598	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						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,634	69,760	100,911	68,588	47,350	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	4,319	4,319	1,076	4,319	0	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	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)	299,511	2,144,656	5,318	1,079,450	1,359,219	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.444516	28.950931	0.052144	14.805849	28.705787	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,156	376,076	74	50,026	218,813	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.139800	5.076688	0.000726	0.686162	4.621183	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: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/20/2024 3:03 pm

		Cost Center Description	CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	11,354					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	134	0	66,740			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,506	0	31,319	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	624	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	49	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	889	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	38	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,024	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	26	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	206	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	253	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	118	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	469	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	220	0	4,580	0	0	73.00
76.00	03950	DIABETIC SERVICES	24	0	509	0	0	76.00
76.01	03020	WOUND CLINIC	73	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
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	4,240	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	1,458	0	30,332	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,354	0	66,740	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE COST CENTER	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)	843,749	0	623,735	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	74.312929	0.000000	9.345745	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	147,786	0	10,187	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	11.963273	0.000000	0.152637	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/20/2024 3:03 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			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
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	115,710,825			16.00
17.00	01700	SOCIAL SERVICE	0	703		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	3,955,037	703		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	12,469,758	0		50.00
53.00	05300	ANESTHESIOLOGY	1,821,730	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,299,149	0		54.00
56.00	05600	RADIOISOTOPE	1,067,343	0		56.00
57.00	05700	CT SCAN	15,145,352	0		57.00
58.00	05800	MRI	3,420,431	0		58.00
60.00	06000	LABORATORY	20,921,573	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400	INTRAVENOUS THERAPY	469,064	0		64.00
65.00	06500	RESPIRATORY THERAPY	1,545,591	0		65.00
66.00	06600	PHYSICAL THERAPY	1,796,037	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	689,455	0		67.00
68.00	06800	SPEECH PATHOLOGY	33,480	0		68.00
69.00	06900	ELECTROCARDIOLOGY	4,425,172	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	166,644	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,303,238	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,848,746	0		73.00
76.00	03950	DIABETIC SERVICES	8,412	0		76.00
76.01	03020	WOUND CLINIC	1,562,477	0		76.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
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	9,351,682	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	831,518	0		88.01
91.00	09100	EMERGENCY	12,578,936	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		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,710,825	703		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		192.00
194.00	07950	NONREIMBURSABLE COST CENTER	0	0		194.00
194.01	07951	RESEARCH	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)	84,291	353,943		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000728	503.475107		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,264	4,950		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000089	7.041252		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/20/2024 3:03 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	4,300,109		4,300,109	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,080,328		2,080,328	0	0	50.00
53.00	05300	ANESTHESIOLOGY	99,230		99,230	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,044,174		2,044,174	0	0	54.00
56.00	05600	RADIOISOTOPE	107,816		107,816	0	0	56.00
57.00	05700	CT SCAN	68,941		68,941	0	0	57.00
58.00	05800	MRI	377,721		377,721	0	0	58.00
60.00	06000	LABORATORY	2,391,634		2,391,634	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	39,408		39,408	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	313,220	0	313,220	0	0	65.00
66.00	06600	PHYSICAL THERAPY	911,715	0	911,715	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	239,526	0	239,526	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,854	0	6,854	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	851,543		851,543	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	239,410		239,410	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	312,029		312,029	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,295,492		2,295,492	0	0	73.00
76.00	03950	DIABETIC SERVICES	124,004		124,004	0	0	76.00
76.01	03020	WOUND CLINIC	804,642		804,642	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
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	8,802,527		8,802,527	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	807,076		807,076	0	0	88.01
91.00	09100	EMERGENCY	3,687,944		3,687,944	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	851,877		851,877		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	31,757,220	0	31,757,220	0	0	200.00
201.00		Less Observation Beds	851,877		851,877		0	201.00
202.00		Total (see instructions)	30,905,343	0	30,905,343	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/20/2024 3:03 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	2,939,901		2,939,901			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,594	12,458,164	12,469,758	0.166830	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,777	1,819,953	1,821,730	0.054470	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	126,194	9,172,955	9,299,149	0.219824	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	1,067,343	1,067,343	0.101013	0.000000	56.00
57.00	05700	CT SCAN	296,504	14,848,848	15,145,352	0.004552	0.000000	57.00
58.00	05800	MRI	35,768	3,384,663	3,420,431	0.110431	0.000000	58.00
60.00	06000	LABORATORY	904,343	20,017,230	20,921,573	0.114314	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	469,064	469,064	0.084014	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	758,081	787,510	1,545,591	0.202654	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	348,157	1,447,880	1,796,037	0.507626	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	175,298	514,157	689,455	0.347414	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	23,407	10,073	33,480	0.204719	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	114,162	4,311,010	4,425,172	0.192432	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	166,644	166,644	1.436655	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,303,238	2,303,238	0.135474	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,807,437	10,041,309	11,848,746	0.193733	0.000000	73.00
76.00	03950	DIABETIC SERVICES	0	8,412	8,412	14.741322	0.000000	76.00
76.01	03020	WOUND CLINIC	0	1,562,477	1,562,477	0.514978	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
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	9,351,682	9,351,682			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	831,518	831,518			88.01
91.00	09100	EMERGENCY	238,354	12,340,582	12,578,936	0.293184	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	178,628	836,508	1,015,136	0.839175	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	7,959,605	107,751,220	115,710,825			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,959,605	107,751,220	115,710,825			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/20/2024 3:03 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03950	DIABETIC SERVICES	0.000000	76.00
76.01	03020	WOUND CLINIC	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
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
88.01	08801	RURAL HEALTH CLINIC II		88.01
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
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: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/20/2024 3:03 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,300,109		4,300,109	0	4,300,109	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,080,328		2,080,328	0	2,080,328	50.00
53.00	05300	ANESTHESIOLOGY	99,230		99,230	0	99,230	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,044,174		2,044,174	0	2,044,174	54.00
56.00	05600	RADIOISOTOPE	107,816		107,816	0	107,816	56.00
57.00	05700	CT SCAN	68,941		68,941	0	68,941	57.00
58.00	05800	MRI	377,721		377,721	0	377,721	58.00
60.00	06000	LABORATORY	2,391,634		2,391,634	0	2,391,634	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	39,408		39,408	0	39,408	64.00
65.00	06500	RESPIRATORY THERAPY	313,220	0	313,220	0	313,220	65.00
66.00	06600	PHYSICAL THERAPY	911,715	0	911,715	0	911,715	66.00
67.00	06700	OCCUPATIONAL THERAPY	239,526	0	239,526	0	239,526	67.00
68.00	06800	SPEECH PATHOLOGY	6,854	0	6,854	0	6,854	68.00
69.00	06900	ELECTROCARDIOLOGY	851,543		851,543	0	851,543	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	239,410		239,410	0	239,410	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	312,029		312,029	0	312,029	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,295,492		2,295,492	0	2,295,492	73.00
76.00	03950	DIABETIC SERVICES	124,004		124,004	0	124,004	76.00
76.01	03020	WOUND CLINIC	804,642		804,642	0	804,642	76.01
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
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	8,802,527		8,802,527	0	8,802,527	88.00
88.01	08801	RURAL HEALTH CLINIC II	807,076		807,076	0	807,076	88.01
91.00	09100	EMERGENCY	3,687,944		3,687,944	0	3,687,944	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	851,877		851,877		851,877	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	31,757,220	0	31,757,220	0	31,757,220	200.00
201.00		Less Observation Beds	851,877		851,877		851,877	201.00
202.00		Total (see instructions)	30,905,343	0	30,905,343	0	30,905,343	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/20/2024 3:03 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,939,901		2,939,901			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,594	12,458,164	12,469,758	0.166830	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,777	1,819,953	1,821,730	0.054470	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	126,194	9,172,955	9,299,149	0.219824	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	1,067,343	1,067,343	0.101013	0.000000	56.00
57.00	05700	CT SCAN	296,504	14,848,848	15,145,352	0.004552	0.000000	57.00
58.00	05800	MRI	35,768	3,384,663	3,420,431	0.110431	0.000000	58.00
60.00	06000	LABORATORY	904,343	20,017,230	20,921,573	0.114314	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	469,064	469,064	0.084014	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	758,081	787,510	1,545,591	0.202654	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	348,157	1,447,880	1,796,037	0.507626	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	175,298	514,157	689,455	0.347414	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	23,407	10,073	33,480	0.204719	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	114,162	4,311,010	4,425,172	0.192432	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	166,644	166,644	1.436655	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,303,238	2,303,238	0.135474	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,807,437	10,041,309	11,848,746	0.193733	0.000000	73.00
76.00	03950	DIABETIC SERVICES	0	8,412	8,412	14.741322	0.000000	76.00
76.01	03020	WOUND CLINIC	0	1,562,477	1,562,477	0.514978	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
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	9,351,682	9,351,682	0.941277	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	831,518	831,518	0.970606	0.000000	88.01
91.00	09100	EMERGENCY	238,354	12,340,582	12,578,936	0.293184	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	178,628	836,508	1,015,136	0.839175	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	7,959,605	107,751,220	115,710,825			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,959,605	107,751,220	115,710,825			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/20/2024 3:03 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.166830	50.00
53.00	05300	ANESTHESIOLOGY	0.054470	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.219824	54.00
56.00	05600	RADIOISOTOPE	0.101013	56.00
57.00	05700	CT SCAN	0.004552	57.00
58.00	05800	MRI	0.110431	58.00
60.00	06000	LABORATORY	0.114314	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0.084014	64.00
65.00	06500	RESPIRATORY THERAPY	0.202654	65.00
66.00	06600	PHYSICAL THERAPY	0.507626	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347414	67.00
68.00	06800	SPEECH PATHOLOGY	0.204719	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192432	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.436655	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.135474	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.193733	73.00
76.00	03950	DIABETIC SERVICES	14.741322	76.00
76.01	03020	WOUND CLINIC	0.514978	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
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	0.941277	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.970606	88.01
91.00	09100	EMERGENCY	0.293184	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.839175	92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part II Date/Time Prepared: 2/20/2024 3:03 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,080,328	264,032	1,816,296	0	0	50.00
53.00	05300	ANESTHESIOLOGY	99,230	11,165	88,065	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,044,174	173,425	1,870,749	0	0	54.00
56.00	05600	RADIOISOTOPE	107,816	2,008	105,808	0	0	56.00
57.00	05700	CT SCAN	68,941	2,158	66,783	0	0	57.00
58.00	05800	MRI	377,721	5,552	372,169	0	0	58.00
60.00	06000	LABORATORY	2,391,634	103,784	2,287,850	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	39,408	872	38,536	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	313,220	21,165	292,055	0	0	65.00
66.00	06600	PHYSICAL THERAPY	911,715	150,142	761,573	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	239,526	13,203	226,323	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,854	1,192	5,662	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	851,543	91,727	759,816	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	239,410	92,574	146,836	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	312,029	4,545	307,484	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,295,492	75,666	2,219,826	0	0	73.00
76.00	03950	DIABETIC SERVICES	124,004	33,926	90,078	0	0	76.00
76.01	03020	WOUND CLINIC	804,642	28,981	775,661	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
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	8,802,527	644,521	8,158,006	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	807,076	92,783	714,293	0	0	88.01
91.00	09100	EMERGENCY	3,687,944	253,076	3,434,868	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	851,877	87,401	764,476	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
200.00		Subtotal (sum of lines 50 thru 199)	27,457,111	2,153,898	25,303,213	0	0	200.00
201.00		Less Observation Beds	851,877	87,401	764,476	0	0	201.00
202.00		Total (line 200 minus line 201)	26,605,234	2,066,497	24,538,737	0	0	202.00

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

Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part II Date/Time Prepared: 2/20/2024 3:03 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,080,328	12,469,758	0.166830		50.00
53.00	05300	ANESTHESIOLOGY	99,230	1,821,730	0.054470		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,044,174	9,299,149	0.219824		54.00
56.00	05600	RADIOISOTOPE	107,816	1,067,343	0.101013		56.00
57.00	05700	CT SCAN	68,941	15,145,352	0.004552		57.00
58.00	05800	MRI	377,721	3,420,431	0.110431		58.00
60.00	06000	LABORATORY	2,391,634	20,921,573	0.114314		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000		62.30
64.00	06400	INTRAVENOUS THERAPY	39,408	469,064	0.084014		64.00
65.00	06500	RESPIRATORY THERAPY	313,220	1,545,591	0.202654		65.00
66.00	06600	PHYSICAL THERAPY	911,715	1,796,037	0.507626		66.00
67.00	06700	OCCUPATIONAL THERAPY	239,526	689,455	0.347414		67.00
68.00	06800	SPEECH PATHOLOGY	6,854	33,480	0.204719		68.00
69.00	06900	ELECTROCARDIOLOGY	851,543	4,425,172	0.192432		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	239,410	166,644	1.436655		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	312,029	2,303,238	0.135474		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,295,492	11,848,746	0.193733		73.00
76.00	03950	DIABETIC SERVICES	124,004	8,412	14.741322		76.00
76.01	03020	WOUND CLINIC	804,642	1,562,477	0.514978		76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000		76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000		76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000		78.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	8,802,527	9,351,682	0.941277		88.00
88.01	08801	RURAL HEALTH CLINIC II	807,076	831,518	0.970606		88.01
91.00	09100	EMERGENCY	3,687,944	12,578,936	0.293184		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	851,877	1,015,136	0.839175		92.00
		OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0.000000		102.00
200.00		Subtotal (sum of lines 50 thru 199)	27,457,111	112,770,924			200.00
201.00		Less Observation Beds	851,877	0			201.00
202.00		Total (line 200 minus line 201)	26,605,234	112,770,924			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/20/2024 3:03 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	264,032	12,469,758	0.021174	0	0	50.00
53.00	05300	ANESTHESIOLOGY	11,165	1,821,730	0.006129	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	173,425	9,299,149	0.018650	29,855	557	54.00
56.00	05600	RADIOISOTOPE	2,008	1,067,343	0.001881	0	0	56.00
57.00	05700	CT SCAN	2,158	15,145,352	0.000142	50,569	7	57.00
58.00	05800	MRI	5,552	3,420,431	0.001623	23,450	38	58.00
60.00	06000	LABORATORY	103,784	20,921,573	0.004961	217,926	1,081	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	872	469,064	0.001859	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	21,165	1,545,591	0.013694	159,497	2,184	65.00
66.00	06600	PHYSICAL THERAPY	150,142	1,796,037	0.083596	35,626	2,978	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,203	689,455	0.019150	22,149	424	67.00
68.00	06800	SPEECH PATHOLOGY	1,192	33,480	0.035603	10,542	375	68.00
69.00	06900	ELECTROCARDIOLOGY	91,727	4,425,172	0.020728	31,289	649	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	92,574	166,644	0.555520	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,545	2,303,238	0.001973	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	75,666	11,848,746	0.006386	405,765	2,591	73.00
76.00	03950	DIABETIC SERVICES	33,926	8,412	4.033048	0	0	76.00
76.01	03020	WOUND CLINIC	28,981	1,562,477	0.018548	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
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	644,521	9,351,682	0.068920	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	92,783	831,518	0.111583	0	0	88.01
91.00	09100	EMERGENCY	253,076	12,578,936	0.020119	4,437	89	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	87,401	1,015,136	0.086098	0	0	92.00
200.00		Total (lines 50 through 199)	2,153,898	112,770,924		991,105	10,973	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/20/2024 3:03 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	0	0	76.00
76.01	03020	WOUND CLINIC	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
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
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/20/2024 3:03 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	12,469,758	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,821,730	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,299,149	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	1,067,343	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	15,145,352	0.000000	57.00
58.00	05800	MRI	0	0	0	3,420,431	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	20,921,573	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	469,064	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,545,591	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,796,037	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	689,455	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	33,480	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,425,172	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	166,644	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,303,238	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,848,746	0.000000	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	8,412	0.000000	76.00
76.01	03020	WOUND CLINIC	0	0	0	1,562,477	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
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	9,351,682	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	831,518	0.000000	88.01
91.00	09100	EMERGENCY	0	0	0	12,578,936	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,015,136	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	112,770,924		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/20/2024 3:03 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
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	29,855	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	50,569	0	0	0	57.00
58.00	05800	MRI	0.000000	23,450	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	217,926	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	159,497	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	35,626	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	22,149	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	10,542	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	31,289	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	405,765	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0.000000	0	0	0	0	76.00
76.01	03020	WOUND CLINIC	0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
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
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
91.00	09100	EMERGENCY	0.000000	4,437	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)		991,105	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/20/2024 3:03 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	0.166830	0	5,177,728	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.054470	0	715,382	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.219824	0	2,182,821	0	0	54.00
56.00	05600	RADIOISOTOPE	0.101013	0	321,761	0	0	56.00
57.00	05700	CT SCAN	0.004552	0	3,783,899	0	0	57.00
58.00	05800	MRI	0.110431	0	784,218	0	0	58.00
60.00	06000	LABORATORY	0.114314	0	5,239,860	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.084014	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.202654	0	278,744	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.507626	0	361,083	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347414	0	124,778	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.204719	0	3,631	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192432	0	1,385,799	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.436655	0	62,710	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.135474	0	1,085,109	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.193733	0	4,029,143	5,491	0	73.00
76.00	03950	DIABETIC SERVICES	14.741322	0	2,020	0	0	76.00
76.01	03020	WOUND CLINIC	0.514978	0	544,540	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
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
88.01	08801	RURAL HEALTH CLINIC II						88.01
91.00	09100	EMERGENCY	0.293184	0	2,799,828	778	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.839175	0	255,027	0	0	92.00
200.00		Subtotal (see instructions)		0	29,138,081	6,269	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	29,138,081	6,269	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/20/2024 3:03 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	863,800	0		50.00
53.00	05300	ANESTHESIOLOGY	38,967	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	479,836	0		54.00
56.00	05600	RADIOISOTOPE	32,502	0		56.00
57.00	05700	CT SCAN	17,224	0		57.00
58.00	05800	MRI	86,602	0		58.00
60.00	06000	LABORATORY	598,989	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	56,489	0		65.00
66.00	06600	PHYSICAL THERAPY	183,295	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	43,350	0		67.00
68.00	06800	SPEECH PATHOLOGY	743	0		68.00
69.00	06900	ELECTROCARDIOLOGY	266,672	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	90,093	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	147,004	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	780,578	1,064		73.00
76.00	03950	DIABETIC SERVICES	29,777	0		76.00
76.01	03020	WOUND CLINIC	280,426	0		76.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
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
88.01	08801	RURAL HEALTH CLINIC II				88.01
91.00	09100	EMERGENCY	820,865	228		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	214,012	0		92.00
200.00		Subtotal (see instructions)	5,031,224	1,292		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,031,224	1,292		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part I | Date/Time Prepared: 2/20/2024 3:03 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	441,184	192,317	248,867	1,087	228.95	30.00
200.00	Total (lines 30 through 199)	441,184		248,867	1,087		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	18	4,121	30.00
200.00	Total (lines 30 through 199)	18	4,121	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/20/2024 3:03 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	264,032	12,469,758	0.021174	0	0	50.00
53.00	05300	ANESTHESIOLOGY	11,165	1,821,730	0.006129	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	173,425	9,299,149	0.018650	1,025	19	54.00
56.00	05600	RADIOISOTOPE	2,008	1,067,343	0.001881	0	0	56.00
57.00	05700	CT SCAN	2,158	15,145,352	0.000142	6,986	1	57.00
58.00	05800	MRI	5,552	3,420,431	0.001623	0	0	58.00
60.00	06000	LABORATORY	103,784	20,921,573	0.004961	15,178	75	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	872	469,064	0.001859	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	21,165	1,545,591	0.013694	15,449	212	65.00
66.00	06600	PHYSICAL THERAPY	150,142	1,796,037	0.083596	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,203	689,455	0.019150	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,192	33,480	0.035603	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	91,727	4,425,172	0.020728	3,506	73	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	92,574	166,644	0.555520	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,545	2,303,238	0.001973	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	75,666	11,848,746	0.006386	21,675	138	73.00
76.00	03950	DIABETIC SERVICES	33,926	8,412	4.033048	0	0	76.00
76.01	03020	WOUND CLINIC	28,981	1,562,477	0.018548	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
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	644,521	9,351,682	0.068920	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	92,783	831,518	0.111583	0	0	88.01
91.00	09100	EMERGENCY	253,076	12,578,936	0.020119	1,953	39	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	87,401	1,015,136	0.086098	1,391	120	92.00
200.00		Total (lines 50 through 199)	2,153,898	112,770,924		67,163	677	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part III Date/Time Prepared: 2/20/2024 3:03 pm

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,087	0.00	18	30.00
200.00		Total (lines 30 through 199)		0	1,087		18	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/20/2024 3:03 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	0	0	76.00
76.01	03020	WOUND CLINIC	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
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
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/20/2024 3:03 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	12,469,758	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,821,730	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,299,149	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	1,067,343	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	15,145,352	0.000000	57.00
58.00	05800	MRI	0	0	0	3,420,431	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	20,921,573	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	469,064	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,545,591	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,796,037	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	689,455	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	33,480	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,425,172	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	166,644	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,303,238	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,848,746	0.000000	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	8,412	0.000000	76.00
76.01	03020	WOUND CLINIC	0	0	0	1,562,477	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
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	9,351,682	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	831,518	0.000000	88.01
91.00	09100	EMERGENCY	0	0	0	12,578,936	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,015,136	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	112,770,924		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/20/2024 3:03 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,025	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	6,986	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	15,178	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	15,449	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	3,506	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	21,675	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0.000000	0	0	0	0	76.00
76.01	03020	WOUND CLINIC	0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
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
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
91.00	09100	EMERGENCY	0.000000	1,953	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,391	0	0	0	92.00
200.00		Total (lines 50 through 199)		67,163	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/20/2024 3:03 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)	2,052	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,087	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)	703	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	210	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)	630	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	31	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)	94	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	385	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)	138	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)	358	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	201.56	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,300,109	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)	6,248	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)	18,947	25.00
26.00	Total swing-bed cost (see instructions)	1,888,676	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,411,433	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,411,433	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,218.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	854,096	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)	854,096	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/20/2024 3:03 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	180,488	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)	1,034,584	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)	306,143	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	794,198	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	1,100,341	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)	384	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,218.43	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1318	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/20/2024 3:03 pm
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	851,877	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	441,184	4,300,109	0.102598	851,877	87,401	90.00
91.00	Nursing Program cost	0	4,300,109	0.000000	851,877	0	91.00
92.00	Allied health cost	0	4,300,109	0.000000	851,877	0	92.00
93.00	All other Medical Education	0	4,300,109	0.000000	851,877	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/20/2024 3:03 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,052	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,087	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)	703	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	210	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)	630	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	31	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)	94	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	18	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)	5	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)	4,300,109	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)	1,874,460	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,425,649	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,425,649	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,231.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	40,167	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)	40,167	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/20/2024 3:03 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	11,737	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)	51,904	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)	4,121	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	677	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	4,798	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	47,106	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)	384	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,231.51	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1318	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/20/2024 3:03 pm
	Title XIX	Hospital	PPS

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	856,900	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	441,184	4,300,109	0.102598	856,900	87,916	90.00
91.00	Nursing Program cost	0	4,300,109	0.000000	856,900	0	91.00
92.00	Allied health cost	0	4,300,109	0.000000	856,900	0	92.00
93.00	All other Medical Education	0	4,300,109	0.000000	856,900	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/20/2024 3:03 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		830,388		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.166830	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.054470	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.219824	29,855	6,563	54.00
56.00	05600	RADIOISOTOPE	0.101013	0	0	56.00
57.00	05700	CT SCAN	0.004552	50,569	230	57.00
58.00	05800	MRI	0.110431	23,450	2,590	58.00
60.00	06000	LABORATORY	0.114314	217,926	24,912	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.084014	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.202654	159,497	32,323	65.00
66.00	06600	PHYSICAL THERAPY	0.507626	35,626	18,085	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347414	22,149	7,695	67.00
68.00	06800	SPEECH PATHOLOGY	0.204719	10,542	2,158	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192432	31,289	6,021	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.436655	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.135474	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.193733	405,765	78,610	73.00
76.00	03950	DIABETIC SERVICES	14.741322	0	0	76.00
76.01	03020	WOUND CLINIC	0.514978	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
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
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	0.293184	4,437	1,301	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.839175	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		991,105	180,488	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)		991,105		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3

Component CCN: 14-Z318 | Date/Time Prepared: 2/20/2024 3:03 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.166830	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.054470	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.219824	14,745	3,241	54.00
56.00	05600	RADIOISOTOPE	0.101013	0	0	56.00
57.00	05700	CT SCAN	0.004552	3,292	15	57.00
58.00	05800	MRI	0.110431	0	0	58.00
60.00	06000	LABORATORY	0.114314	136,589	15,614	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.084014	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.202654	169,742	34,399	65.00
66.00	06600	PHYSICAL THERAPY	0.507626	157,144	79,770	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347414	81,548	28,331	67.00
68.00	06800	SPEECH PATHOLOGY	0.204719	1,876	384	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192432	975	188	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.436655	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.135474	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.193733	367,682	71,232	73.00
76.00	03950	DIABETIC SERVICES	14.741322	0	0	76.00
76.01	03020	WOUND CLINIC	0.514978	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
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
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	0.293184	1,676	491	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.839175	2,855	2,396	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		938,124	236,061	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)		938,124		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/20/2024 3:03 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		38,284		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.166830	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.054470	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.219824	1,025	225	54.00
56.00	05600	RADIOISOTOPE	0.101013	0	0	56.00
57.00	05700	CT SCAN	0.004552	6,986	32	57.00
58.00	05800	MRI	0.110431	0	0	58.00
60.00	06000	LABORATORY	0.114314	15,178	1,735	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.084014	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.202654	15,449	3,131	65.00
66.00	06600	PHYSICAL THERAPY	0.507626	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347414	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.204719	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192432	3,506	675	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.436655	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.135474	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.193733	21,675	4,199	73.00
76.00	03950	DIABETIC SERVICES	14.741322	0	0	76.00
76.01	03020	WOUND CLINIC	0.514978	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
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	0.941277	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.970606	0	0	88.01
91.00	09100	EMERGENCY	0.293184	1,953	573	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.839175	1,391	1,167	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		67,163	11,737	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)		67,163		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E Part B Date/Time Prepared: 2/20/2024 3:03 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,032,516	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)	5,032,516	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)	5,082,841	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)	53,934	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,603,094	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)	425,813	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)	425,813	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	425,813	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)	83,851	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	54,503	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	72,944	36.00
37.00	Subtotal (see instructions)	480,316	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)	480,316	40.00
40.01	Sequestration adjustment (see instructions)	9,606	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	-15,466	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)	486,176	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	59,742	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: 14-1318	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/20/2024 3:03 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: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I Date/Time Prepared: 2/20/2024 3:03 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		901,094		937,655	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	05/25/2023	41,599	05/25/2023	812,551	3.50
3.51		09/05/2023	10,861	09/05/2023	140,570	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)		-52,460		-953,121	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)		848,634		-15,466	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		41,815		486,176	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		890,449		470,710	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: 14-1318 | Component CCN: 14-Z318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/20/2024 3:03 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		1,236,080		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	05/25/2023	37,039		0	3.50
3.51		09/05/2023	13,652		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)		-50,691		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,185,389		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		125,025		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,310,414		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: 14-1318	Period: From 10/01/2022 To 09/30/2023	Worksheet E-1 Part II Date/Time Prepared: 2/20/2024 3:03 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: 14-1318 | Component CCN: 14-Z318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-2 | Date/Time Prepared: 2/20/2024 3:03 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)	1,111,344	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)	238,422	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	496	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)	1,349,766	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,349,766	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)	1,349,766	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	13,241	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,336,525	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)	973	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	632	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	973	0	18.00
19.00	Total (see instructions)	1,337,157	0	19.00
19.01	Sequestration adjustment (see instructions)	26,743	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	1,185,389	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)	125,025	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: 14-1318	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part V Date/Time Prepared: 2/20/2024 3:03 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,034,584	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)	1,034,584	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,044,930	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)	1,044,930	19.00
20.00	Deductibles (exclude professional component)	151,032	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	893,898	22.00
23.00	Coinsurance	800	23.00
24.00	Subtotal (line 22 minus line 23)	893,098	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	23,882	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	15,523	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	20,842	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	908,621	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)	908,621	30.00
30.01	Sequestration adjustment (see instructions)	18,172	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	848,634	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)	41,815	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	8,200	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G | Date/Time Prepared: 2/20/2024 3:03 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	67,616,501	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	11,042,921	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,290,056	0	0	0	6.00
7.00	Inventory	283,995	0	0	0	7.00
8.00	Prepaid expenses	2,975	0	0	0	8.00
9.00	Other current assets	296,220	0	0	0	9.00
10.00	Due from other funds	2,699,714	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	75,652,270	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	325,000	0	0	0	12.00
13.00	Land improvements	484,925	0	0	0	13.00
14.00	Accumulated depreciation	-351,339	0	0	0	14.00
15.00	Buildings	27,087,416	0	0	0	15.00
16.00	Accumulated depreciation	-8,993,446	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	9,846,919	0	0	0	23.00
24.00	Accumulated depreciation	-6,429,706	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	366,272	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	22,336,041	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,747,969	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	6,631,798	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,379,767	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	106,368,078	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	676,608	0	0	0	37.00
38.00	Salaries, wages, and fees payable	208,722	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	662,323	0	0	0	43.00
44.00	Other current liabilities	115,126	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,662,779	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	113,494	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	113,494	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	1,776,273	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	104,591,805				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)	104,591,805	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	106,368,078	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-1 | Date/Time Prepared: 2/20/2024 3:03 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		88,689,047		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		18,048,667				2.00
3.00	Total (sum of line 1 and line 2)		106,737,714		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		106,737,714		0		11.00
12.00	EQUITY TRANSFER	2,145,909		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)		2,145,909		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		104,591,805		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	EQUITY TRANSFER		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: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/20/2024 3:03 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,589,492		1,589,492	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,175,485		1,175,485	5.00
6.00	Swing bed - NF	174,923		174,923	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)	2,939,900		2,939,900	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,939,900		2,939,900	17.00
18.00	Ancillary services	4,602,722	84,390,930	88,993,652	18.00
19.00	Outpatient services	416,982	13,177,090	13,594,072	19.00
20.00	RURAL HEALTH CLINIC	0	9,351,682	9,351,682	20.00
20.01	RURAL HEALTH CLINIC II	0	831,518	831,518	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	ROUNDING	0	1	1	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,959,604	107,751,221	115,710,825	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,708,814		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)		33,708,814		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1318 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-3 | Date/Time Prepared: 2/20/2024 3:03 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	115,710,825	1.00
2.00	Less contractual allowances and discounts on patients' accounts	68,699,514	2.00
3.00	Net patient revenues (line 1 minus line 2)	47,011,311	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	33,708,814	4.00
5.00	Net income from service to patients (line 3 minus line 4)	13,302,497	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	2,841,823	6.00
7.00	Income from investments	-44,667	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	74,262	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	670,706	17.00
18.00	Revenue from sale of medical records and abstracts	40	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	4,704	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,199,315	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	4,746,183	25.00
26.00	Total (line 5 plus line 25)	18,048,680	26.00
27.00	ROUNDING	13	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	13	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	18,048,667	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1318 | Component CCN: 14-3461 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/20/2024 3:03 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	796,095	0	796,095	-5,620	790,475	1.00
2.00	Physician Assistant	422,854	0	422,854	-2,397	420,457	2.00
3.00	Nurse Practitioner	577,417	0	577,417	-8,975	568,442	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,495,254	0	1,495,254	8,180	1,503,434	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	135,863	0	135,863	1,047	136,910	7.00
8.00	Laboratory Technician	0	36,793	36,793	0	36,793	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)	3,427,483	36,793	3,464,276	-7,765	3,456,511	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	358,284	358,284	0	358,284	15.00
16.00	Transportation (Health Care Staff)	0	5,513	5,513	0	5,513	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	6,123	6,123	0	6,123	18.00
19.00	Other Health Care Costs	0	6,576	6,576	0	6,576	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	376,496	376,496	0	376,496	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,427,483	413,289	3,840,772	-7,765	3,833,007	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	15,938	15,938	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	15,938	15,938	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	15,897	15,897	-13,738	2,159	29.00
30.00	Administrative Costs	388,887	1,805,093	2,193,980	-1,026,824	1,167,156	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	388,887	1,820,990	2,209,877	-1,040,562	1,169,315	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,816,370	2,234,279	6,050,649	-1,032,389	5,018,260	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1318 | Component CCN: 14-3461 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/20/2024 3:03 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	-13,700	776,775		1.00
2.00	Physician Assistant	0	420,457		2.00
3.00	Nurse Practitioner	0	568,442		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	1,503,434		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	136,910		7.00
8.00	Laboratory Technician	0	36,793		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-13,700	3,442,811		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	358,284		15.00
16.00	Transportation (Health Care Staff)	0	5,513		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	6,123		18.00
19.00	Other Health Care Costs	0	6,576		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	376,496		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-13,700	3,819,307		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	15,938		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	15,938		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	2,159		29.00
30.00	Administrative Costs	-317,019	850,137		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-317,019	852,296		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-330,719	4,687,541		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1318 | Component CCN: 14-8621 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/20/2024 3:03 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	9,233	9,233	1.00
2.00	Physician Assistant	0	0	0	1,321	1,321	2.00
3.00	Nurse Practitioner	117,649	0	117,649	8,334	125,983	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	123,388	0	123,388	866	124,254	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	241,037	0	241,037	19,754	260,791	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	26,974	26,974	0	26,974	15.00
16.00	Transportation (Health Care Staff)	0	1,800	1,800	0	1,800	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	389	389	0	389	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	29,163	29,163	0	29,163	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	241,037	29,163	270,200	19,754	289,954	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	331	331	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	331	331	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	5,780	5,780	-2,742	3,038	29.00
30.00	Administrative Costs	47,319	168,403	215,722	-80,580	135,142	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	47,319	174,183	221,502	-83,322	138,180	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	288,356	203,346	491,702	-63,237	428,465	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1318 | Component CCN: 14-8621 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/20/2024 3:03 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-12,000	-2,767		1.00
2.00	Physician Assistant	0	1,321		2.00
3.00	Nurse Practitioner	0	125,983		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	124,254		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-12,000	248,791		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	26,974		15.00
16.00	Transportation (Health Care Staff)	0	1,800		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	389		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	29,163		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-12,000	277,954		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	331		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	331		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	3,038		29.00
30.00	Administrative Costs	-30,363	104,779		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-30,363	107,817		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-42,363	386,102		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1318 Component CCN: 14-3461

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

Worksheet M-2 Date/Time Prepared: 2/20/2024 3:03 pm

RHC I

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.76	8,340	4,200	7,392		1.00
2.00	Physician Assistant	2.36	8,339	2,100	4,956		2.00
3.00	Nurse Practitioner	3.49	12,011	2,100	7,329		3.00
4.00	Subtotal (sum of lines 1 through 3)	7.61	28,690		19,677	28,690	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	1.37	1,734			1,734	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)	8.98	30,424			30,424	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)					3,819,307	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					15,938	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,835,245	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.995844	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					852,296	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					4,114,986	15.00
16.00	Total overhead (sum of lines 14 and 15)					4,967,282	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					4,967,282	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					4,946,638	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					8,765,945	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1318 Component CCN: 14-8621

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

Worksheet M-2

Date/Time Prepared: 2/20/2024 3:03 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC II Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.03	120	4,200	126		1.00
2.00	Physician Assistant	0.01	30	2,100	21		2.00
3.00	Nurse Practitioner	0.91	2,438	2,100	1,911		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.95	2,588		2,058	2,588	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.95	2,588			2,588	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)					277,954	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					331	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					278,285	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.998811	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					107,817	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					420,974	15.00
16.00	Total overhead (sum of lines 14 and 15)					528,791	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					528,791	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					528,162	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					806,116	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1318 Component CCN: 14-3461	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/20/2024 3:03 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)		8,765,945	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		441,376	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		8,324,569	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		30,424	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)		30,424	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		273.62	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)	308.78	320.51	8.00
9.00	Rate for Program covered visits (see instructions)	273.62	273.62	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,473	4,300	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	403,042	1,176,566	11.00
12.00	Program covered visits for mental health services (from contractor records)	47	104	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	12,860	28,456	13.00
14.00	Limit adjustment for mental health services (see instructions)	12,860	28,456	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	1,620,924	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,532,025	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		21,971	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		23,246	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.)		1,153,114	16.04
16.05	Total program cost (see instructions)	0	1,176,360	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		156,285	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		269,516	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,176,360	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		121,369	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,297,729	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)		1,297,729	26.00
26.01	Sequestration adjustment (see instructions)		25,955	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		1,216,889	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)		54,885	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1318 Component CCN: 14-8621	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/20/2024 3:03 pm
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		806,116	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		58,641	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		747,475	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		2,588	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)		2,588	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		288.82	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)	280.66	291.33	8.00
9.00	Rate for Program covered visits (see instructions)	280.66	288.82	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	186	401	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	52,203	115,817	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	168,020	16.00
16.01	Total program charges (see instructions)(from contractor's records)		153,352	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,502	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,646	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.)		117,438	16.04
16.05	Total program cost (see instructions)	0	119,084	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		19,576	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		26,415	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		119,084	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		20,266	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		139,350	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)		139,350	26.00
26.01	Sequestration adjustment (see instructions)		2,787	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		116,307	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)		20,256	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: 14-1318 | Component CCN: 14-3461 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/20/2024 3:03 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)	3,442,811	3,442,811	3,442,811	3,442,811	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002323	0.007113	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	7,998	24,489	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	117,307	42,514	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	125,305	67,003	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,819,307	3,819,307	3,819,307	3,819,307	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	4,946,638	4,946,638	4,946,638	4,946,638	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.032808	0.017543	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	162,289	86,779	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	287,594	153,782	0	0	10.00
11.00	Total number of injections/infusions (from your records)	563	1,724	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	510.82	89.20	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	144	536	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	73,558	47,811	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		441,376	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)		121,369	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1318 | Component CCN: 14-8621 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/20/2024 3:03 pm

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	248,791	248,791	248,791	248,791	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002579	0.010085	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	642	2,509	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	11,668	5,401	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	12,310	7,910	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	277,954	277,954	277,954	277,954	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	528,162	528,162	528,162	528,162	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.044288	0.028458	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	23,391	15,030	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	35,701	22,940	0	0	10.00
11.00	Total number of injections/infusions (from your records)	56	219	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	637.52	104.75	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	17	90	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	10,838	9,428	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		58,641	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)		20,266	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1318 Component CCN: 14-3461	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/20/2024 3:03 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		1,302,704	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		05/25/2023	85,815	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)		-85,815	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,216,889	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		54,885	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,271,774	7.00

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

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

Provider CCN: 14-1318 | Component CCN: 14-8621 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-5 | Date/Time Prepared: 2/20/2024 3:03 pm

RHC II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		130,691	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		05/25/2023	14,384	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)		-14,384	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		116,307	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		20,256	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		136,563	7.00

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