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: 14-1315	Period: From 10/01/2022 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/29/2024 11:18 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/29/2024 Time: 11:18 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BCC DBA ILLINI COMMUNITY HOSPITAL (14-1315) 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	Patrick Gerveler		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Patrick Gerveler			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-174,895	-428,869	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	17,213	-44		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-43,188		0	10.00
200.00	TOTAL	0	-157,682	-472,101	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/29/2024 11:18 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 640 WEST WASHINGTON	PO Box:			1.00
2.00	City: PITTSFIELD	State: IL	Zip Code: 62363	County: PIKE	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	BCC DBA ILLINI COMMUNITY HOSPITAL	141315	99914	1	09/01/2001	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	BCC DBA ILLINI COMM HOSP-SWINGBED	14Z315	99914		09/01/2001	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	BCC DBA ILLINI COMM HOSP RHC	143482	99914		07/03/2006	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2022	09/30/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/29/2024 11:18 am

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/29/2024 11:18 am

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

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					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	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N	109.00

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

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

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/29/2024 11:18 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	75,331	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	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	14H132	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: BLESSING CORPORATE SERVICES	Contractor's Name: NATIONAL GOVERNMENT SERVICES	Contractor's Number: 131	141.00
142.00	Street: BROADWAY AT 11TH STREET	PO Box:		142.00
143.00	City: QUINCY	State: IL	Zip Code: 62301	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: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/29/2024 11:18 am

					1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
					1.00	
	Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

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

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.00	169.00
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/29/2024 11:18 am

			Y/N	Date	
			1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE				
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	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	12/31/2023	Y	12/31/2023 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: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/29/2024 11:18 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	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.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONNIE	ZIEGLER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLESSING CORPORATE SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-223-8400, X4159	CONNIE.ZIEGLER@BLESSINGHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1315	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part II Date/Time Prepared: 2/29/2024 11:18 am

		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.	REIMBURSEMENT COORDINATOR		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: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/29/2024 11:18 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	26,184.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	26,184.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	26,184.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/29/2024 11:18 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	651	12	1,091			1.00
2.00	HMO and other (see instructions)	252	102				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	523	0	523			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	225			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,174	12	1,839			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,174	12	1,839	0.00	162.81	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	2,659	0	14,081	0.00	22.12	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	184.93	27.00
28.00	Observation Bed Days		0	192			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			76			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: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/29/2024 11:18 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	210	5	375	1.00
2.00	HMO and other (see instructions)			89	38		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	210	5	375	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1315 | Component CCN: 14-3482 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/29/2024 11:18 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			640 WEST WASHINGTON		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	PITTSFIELD		IL	62363	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	07:00	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		PIKE				2.00

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1315
Component CCN: 14-3482

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

Worksheet S-8
Date/Time Prepared:
2/29/2024 11:18 am

RHC I

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1315	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/29/2024 11:18 am

		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)	0.382300	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,987,373	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?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,066,397	5.00
6.00	Medicaid charges	16,655,816	6.00
7.00	Medicaid cost (line 1 times line 6)	6,367,518	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	2,313,748	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)	2,313,748	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)	303,945	411,823	715,768	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	116,198	411,823	528,021	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)	116,198	411,823	528,021	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)	1,691,332	26.00
27.00	Medicare reimbursable bad debts (see instructions)	292,587	27.00
27.01	Medicare allowable bad debts (see instructions)	450,134	27.01
28.00	Non-Medicare bad debt amount (see instructions)	1,241,198	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	632,057	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,160,078	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,473,826	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1315	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/29/2024 11:18 am

		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: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/29/2024 11:18 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		795,908	795,908	25,191	821,099	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		500,741	500,741	3,434	504,175	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	521,665	5,016,726	5,538,391	-9,743	5,528,648	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,905,643	4,153,714	6,059,357	59,253	6,118,610	5.00
6.00	00600	MAINTENANCE & REPAIRS	534,822	342,783	877,605	0	877,605	6.00
7.00	00700	OPERATION OF PLANT	0	617,824	617,824	40,034	657,858	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	38,875	38,875	0	38,875	8.00
9.00	00900	HOUSEKEEPING	468,398	141,214	609,612	0	609,612	9.00
10.00	01000	DIETARY	239,455	90,382	329,837	0	329,837	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	312,589	9,238	321,827	-90,303	231,524	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,482	22,482	0	22,482	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	122,367	122,367	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	216,519	216,519	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,766,360	86,385	1,852,745	-90,217	1,762,528	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	650,512	74,563	725,075	10,777	735,852	50.00
53.00	05300	ANESTHESIOLOGY	216,519	12,687	229,206	-229,206	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	944,519	433,324	1,377,843	0	1,377,843	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	82,917	30,471	113,388	0	113,388	54.01
60.00	06000	LABORATORY	439,042	2,013,974	2,453,016	0	2,453,016	60.00
65.00	06500	RESPIRATORY THERAPY	52,238	35,709	87,947	0	87,947	65.00
65.01	03610	SLEEP LAB	0	22,624	22,624	0	22,624	65.01
66.00	06600	PHYSICAL THERAPY	0	64,433	64,433	0	64,433	66.00
67.00	06700	OCCUPATIONAL THERAPY	61,289	9,568	70,857	0	70,857	67.00
68.00	06800	SPEECH PATHOLOGY	27,548	2,080	29,628	0	29,628	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	58,904	305,739	364,643	1,910	366,553	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	443,964	2,602,576	3,046,540	0	3,046,540	73.00
73.01	03480	ONCOLOGY	115,631	131,720	247,351	0	247,351	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,490,855	129,671	2,620,526	0	2,620,526	88.00
91.00	09100	EMERGENCY	3,166,351	1,680,248	4,846,599	-32,150	4,814,449	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		34,437	34,437	0	34,437	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,499,221	19,400,096	33,899,317	27,866	33,927,183	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	31,505	1,670	33,175	0	33,175	192.00
192.01	19201	XPRESS CARE	446,713	60,264	506,977	0	506,977	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	0	0	0	0	193.01
193.02	19302	LEASED SPACE	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	WELLNESS	32,229	41,346	73,575	-27,866	45,709	193.04
193.05	19305	RETAIL PHARMACY	12,571	8,242	20,813	0	20,813	193.05
200.00		TOTAL (SUM OF LINES 118 through 199)	15,022,239	19,511,618	34,533,857	0	34,533,857	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/29/2024 11:18 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	112,441	933,540		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	123,532	627,707		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,508,560	4,020,088		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	146,932	6,265,542		5.00
6.00	00600	MAINTENANCE & REPAIRS	-12,897	864,708		6.00
7.00	00700	OPERATION OF PLANT	-7,185	650,673		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	856	39,731		8.00
9.00	00900	HOUSEKEEPING	0	609,612		9.00
10.00	01000	DIETARY	-15,993	313,844		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	231,524		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	345,849	368,331		16.00
17.00	01700	SOCIAL SERVICE	186,707	309,074		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	216,519		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-17,021	1,745,507		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-4,948	730,904		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-51,412	1,326,431		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	-99	113,289		54.01
60.00	06000	LABORATORY	-601,224	1,851,792		60.00
65.00	06500	RESPIRATORY THERAPY	0	87,947		65.00
65.01	03610	SLEEP LAB	-4,963	17,661		65.01
66.00	06600	PHYSICAL THERAPY	0	64,433		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	70,857		67.00
68.00	06800	SPEECH PATHOLOGY	0	29,628		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	93,441	459,994		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,007	3,083,547		73.00
73.01	03480	ONCOLOGY	-182,954	64,397		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	11,345	2,631,871		88.00
91.00	09100	EMERGENCY	-1,010,401	3,804,048		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-34,437	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,393,984	31,533,199		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	33,175		192.00
192.01	19201	XPRESS CARE	-158	506,819		192.01
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	RENAL	0	0		193.01
193.02	19302	LEASED SPACE	0	0		193.02
193.03	19303	UNUSED SPACE	0	0		193.03
193.04	19304	WELLNESS	0	45,709		193.04
193.05	19305	RETAIL PHARMACY	0	20,813		193.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,394,142	32,139,715		200.00

RECLASSIFICATIONS | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/29/2024 11:18 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	10,000	1.00
	0		0	10,000	
	B - RECLASS UTILITIES				
1.00	OPERATION OF PLANT	7.00	0	40,034	1.00
2.00		0.00	0	0	2.00
	0		0	40,034	
	C - RECLASS MEDICAL SUPPLIES EXPENSE				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,910	1.00
	0		0	1,910	
	E - RECLASS INFECTION CONTROL SALARY				
1.00	ADMINISTRATIVE & GENERAL	5.00	90,303	0	1.00
	0		90,303	0	
	F - RECLASS MISCELLANEOUS ANESTH EXPENSE				
1.00	OPERATING ROOM	50.00	0	12,687	1.00
	0		0	12,687	
	H - RECLASS CRNA COSTS				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	216,519	0	1.00
	0		216,519	0	
	J - RECLASS SOCIAL WORKER SALARIES				
1.00	SOCIAL SERVICE	17.00	122,367	0	1.00
2.00		0.00	0	0	2.00
	0		122,367	0	
	K - RECLASS BUILDING RENT				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	18,625	1.00
	0		0	18,625	
	L - RECLASS EMPLOYEE BENEFIT PERCENTAGE				
1.00	ADMINISTRATIVE & GENERAL	5.00	4,048	5,193	1.00
	0		4,048	5,193	
500.00	Grand Total: Increases		433,237	88,449	500.00

RECLASSIFICATIONS | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/29/2024 11:18 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,000	0		1.00
	0		0	10,000			
	B - RECLASS UTILITIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9,743	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	30,291	0		2.00
	0		0	40,034			
	C - RECLASS MEDICAL SUPPLIES EXPENSE						
1.00	OPERATING ROOM	50.00	0	1,910	0		1.00
	0		0	1,910			
	E - RECLASS INFECTION CONTROL SALARY						
1.00	NURSING ADMINISTRATION	13.00	90,303	0	0		1.00
	0		90,303	0			
	F - RECLASS MISCELLANEOUS ANESTH EXPENSE						
1.00	ANESTHESIOLOGY	53.00	0	12,687	0		1.00
	0		0	12,687			
	H - RECLASS CRNA COSTS						
1.00	ANESTHESIOLOGY	53.00	216,519	0	0		1.00
	0		216,519	0			
	J - RECLASS SOCIAL WORKER SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	90,217	0	0		1.00
2.00	EMERGENCY	91.00	32,150	0	0		2.00
	0		122,367	0			
	K - RECLASS BUILDING RENT						
1.00	WELLNESS	193.04	0	18,625	10		1.00
	0		0	18,625			
	L - RECLASS EMPLOYEE BENEFIT PERCENTAGE						
1.00	WELLNESS	193.04	4,048	5,193	0		1.00
	0		4,048	5,193			
500.00	Grand Total: Decreases		433,237	88,449			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 2/29/2024 11:18 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	297,566	0	0	0	10,010	1.00
2.00	Land Improvements	556,314	62,500	0	62,500	0	2.00
3.00	Buildings and Fixtures	13,081,861	0	0	0	70,000	3.00
4.00	Building Improvements	5,840,292	93,899	0	93,899	103,508	4.00
5.00	Fixed Equipment	73,264	0	0	0	0	5.00
6.00	Movable Equipment	9,425,128	483,418	0	483,418	55,330	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,274,425	639,817	0	639,817	238,848	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	29,274,425	639,817	0	639,817	238,848	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	287,556	0	1.00
2.00	Land Improvements	618,814	0	2.00
3.00	Buildings and Fixtures	13,011,861	0	3.00
4.00	Building Improvements	5,830,683	0	4.00
5.00	Fixed Equipment	73,264	0	5.00
6.00	Movable Equipment	9,853,216	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,675,394	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	29,675,394	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 2/29/2024 11:18 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	795,908	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	500,741	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,296,649	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	795,908	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	500,741	2.00
3.00	Total (sum of lines 1-2)	0	1,296,649	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 2/29/2024 11:18 am

	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	18,842,543	0	18,842,543	0.656632	6,566	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,853,216	0	9,853,216	0.343368	3,434	2.00
3.00	Total (sum of lines 1-2)	28,695,759	0	28,695,759	1.000000	10,000	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	6,566	908,349	18,625	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	3,434	624,273	0	2.00
3.00	Total (sum of lines 1-2)	0	0	10,000	1,532,622	18,625	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	6,566	0	0	933,540	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,434	0	0	627,707	2.00
3.00	Total (sum of lines 1-2)	0	10,000	0	0	1,561,247	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/29/2024 11:18 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-34,437	INTEREST EXPENSE	113.00	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)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-824,362			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	65,254			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-12,125	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-12,064	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/29/2024 11:18 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	UTILITY REBATES	B	-3,111	OPERATION OF PLANT	7.00	0	33.01
33.02	MISCELLANEOUS SUPPLIES REVENUE	B	-543	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.02
33.03	MISCELLANEOUS	B	-1,458	DIETARY	10.00	0	33.03
33.04	CABLE TELEVISION	A	-4,074	OPERATION OF PLANT	7.00	0	33.04
33.05	MISCELLANEOUS EXPENSE	A	-2,068	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PUBLIC RELATIONS EXPENSES	A	-58,462	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	ASSET RELIFING	A	112,441	CAP REL COSTS-BLDG & FIXT	1.00	9	33.07
33.08	ASSET RELIFING	A	125,191	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09	LOBBYING EXPENSE	A	-14,973	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	MISCELLANEOUS	B	-215	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	MISCELLANEOUS	B	-1,583	RADIOLOGY-DIAGNOSTIC	54.00	0	33.11
33.12	MISCELLANEOUS	B	-36,020	RADIOLOGY-DIAGNOSTIC	54.00	0	33.12
33.13	MISCELLANEOUS	B	-209	DIETARY	10.00	0	33.13
33.14	ACCOUNTING FEES	B	-2,577	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	LABORATORY EXPENSE	A	-763	RURAL HEALTH CLINIC	88.00	0	33.15
33.16	CT SCANNER DEPRECIATION ADJUSTMENT	A	-1,659	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.16
33.17	PHYSICIAN TAIL COVERAGE	A	3,291	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	CONTRACT PHARMACY DISPENSING FEES	A	-10,344	DRUGS CHARGED TO PATIENTS	73.00	0	33.18
33.19	NURSE PRACTITIONER WAGES	A	-16,447	ADULTS & PEDIATRICS	30.00	0	33.19
33.20	NURSE PRACTITIONER WAGES	A	-55,178	ONCOLOGY	73.01	0	33.20
33.21	NURSE PRACTITIONER WAGES	A	-312,301	EMERGENCY	91.00	0	33.21
33.22	NURSE PRACTITIONER BENEFITS	A	-126,235	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.22
33.23	PROVIDER TAX	A	-818,846	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	SHORT TERN DISABILITY	B	-7,438	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.24
33.25	CHILD CARE REVENUE	B	-203,694	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.25
33.26	MISCELLANEOUS	B	-8,098	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.26
33.27	TRANSPORTATION WAGES	A	-76,591	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28	TRANSPORTATION BENEFITS	A	-25,183	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.28
33.29	TRANSPORTATION EXPENSES	A	-29,261	ADMINISTRATIVE & GENERAL	5.00	0	33.29
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,394,142				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: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/29/2024 11:18 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	3,676,633	2,504,954	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	345,849	0	2.00
3.00	17.00	SOCIAL SERVICE	CARE MANAGEMENT	186,707	0	3.00
4.00	10.00	DIETARY	DIETICIAN	6,567	8,768	4.00
4.01	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	95,912	95,056	4.01
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	0	1,137,912	4.02
4.03	73.00	DRUGS CHARGED TO PATIENTS	PHARMACY SERVICE	112,902	65,551	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	CARE MANAGEMENT	0	12,942	4.04
4.05	60.00	LABORATORY	LABORATORY TESTS	303,528	958,600	4.05
4.06	65.01	SLEEP LAB	SLEEP STUDIES	17,578	22,541	4.06
4.07	30.00	ADULTS & PEDIATRICS	BIO-MED	1,314	2,853	4.07
4.08	50.00	OPERATING ROOM	BIO-MED	562	1,220	4.08
4.09	91.00	EMERGENCY	BIO-MED	1,292	2,806	4.09
4.10	50.00	OPERATING ROOM	BIO-MED	225	488	4.10
4.11	50.00	OPERATING ROOM	BIO-MED	3,437	7,464	4.11
4.12	192.01	XPRESS CARE	BIO-MED	135	293	4.12
4.13	88.00	RURAL HEALTH CLINIC	BIO-MED	154	336	4.13
4.14	60.00	LABORATORY	BIO-MED	28	61	4.14
4.15	54.00	RADIOLOGY-DIAGNOSTIC	BIO-MED	11,758	25,534	4.15
4.16	54.00	RADIOLOGY-DIAGNOSTIC	BIO-MED	28	61	4.16
4.17	54.01	NUCLEAR MEDICINE - DIAGNOSTI	BIO-MED	84	183	4.17
4.18	6.00	MAINTENANCE & REPAIRS	BIO-MED	11,009	23,906	4.18
4.19	5.00	ADMINISTRATIVE & GENERAL	BIO-MED	34	73	4.19
4.20	30.00	ADULTS & PEDIATRICS	TELEMETRY SERVICES	11,975	11,010	4.20
4.21	71.00	MEDICAL SUPPLIES CHARGED TO	LOGISTICS MANAGER	93,984	0	4.21
4.22	60.00	LABORATORY	RIVERCROSS LABORATORY TESTS	95,591	41,710	4.22
4.23	88.00	RURAL HEALTH CLINIC	RURAL HEALTH CLINIC MANAGER	12,290	0	4.23
4.27	0.00			0	0	4.27
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,989,576	4,924,322	5.00

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

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

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

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

6.00	B		0.00	BLESS CORP SVCS	0.00	6.00
7.00	G		0.00	BLESSING HOSP	0.00	7.00
8.00	G		0.00	DENMAN SERVICES	0.00	8.00
9.00	G		0.00	DENMAN SERVICES	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	BROTHER/SISTER				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: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/29/2024 11:18 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,171,679	0		1.00
2.00	345,849	0		2.00
3.00	186,707	0		3.00
4.00	-2,201	0		4.00
4.01	856	0		4.01
4.02	-1,137,912	0		4.02
4.03	47,351	0		4.03
4.04	-12,942	0		4.04
4.05	-655,072	0		4.05
4.06	-4,963	0		4.06
4.07	-1,539	0		4.07
4.08	-658	0		4.08
4.09	-1,514	0		4.09
4.10	-263	0		4.10
4.11	-4,027	0		4.11
4.12	-158	0		4.12
4.13	-182	0		4.13
4.14	-33	0		4.14
4.15	-13,776	0		4.15
4.16	-33	0		4.16
4.17	-99	0		4.17
4.18	-12,897	0		4.18
4.19	-39	0		4.19
4.20	965	9		4.20
4.21	93,984	0		4.21
4.22	53,881	0		4.22
4.23	12,290	0		4.23
4.27	0	0		4.27
5.00	65,254			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	HOSPITAL		7.00
8.00	LAUNDRY		8.00
9.00	BIO-MED		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: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 2/29/2024 11:18 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	29,948	0	29,948	0	0	1.00
2.00	73.01	ONCOLOGY	127,776	127,776	0	0	0	2.00
3.00	91.00	EMERGENCY	2,842,172	672,187	2,169,985	0	0	3.00
4.00	91.00	EMERGENCY	24,399	24,399	0	0	0	4.00
5.00	13.00	NURSING ADMINISTRATION	5,950	0	5,950	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,030,245	824,362	2,205,883		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	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	73.01	ONCOLOGY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	0		1.00
2.00	73.01	ONCOLOGY	0	0	0	127,776		2.00
3.00	91.00	EMERGENCY	0	0	0	672,187		3.00
4.00	91.00	EMERGENCY	0	0	0	24,399		4.00
5.00	13.00	NURSING ADMINISTRATION	0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	824,362		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1315	Period: From 10/01/2022 To 09/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/29/2024 11:18 am

		Physical Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		238	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		3.45	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	676.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	96.24	72.18	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)	48.12	48.12	36.09			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)		65,058	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)		65,058	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)		65,058	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)		96.24	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		75,067	22.00
23.00	Total salary equivalency (see instructions)		75,067	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)		11,453	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)		11,453	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)		821	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		12,274	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)		12,274	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: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/29/2024 11:18 am

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)	96.24	72.18	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)	75,067		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	12,274		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)	87,341		63.00
64.00	Total cost of outside supplier services (from your records)	64,433		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	11,453		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	821		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	12,274		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	821		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	821		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1315	Period: From 10/01/2022 To 09/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/29/2024 11:18 am

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		82	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		3.45	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	97.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	91.21	68.41	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)	45.61	45.61	34.21			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)	8,847	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)	8,847	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)	8,847	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)	91.21	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	71,144	22.00
23.00	Total salary equivalency (see instructions)	71,144	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)	3,740	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)	3,740	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)	283	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	4,023	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	4,023	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1315	Period: From 10/01/2022 To 09/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/29/2024 11:18 am

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	91.21	68.41	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)	71,144	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	4,023	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)	75,167	63.00
64.00	Total cost of outside supplier services (from your records)	9,266	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	3,740	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	283	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	4,023	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	283	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	283	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/29/2024 11:18 am

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					21	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					3.45	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	32.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	87.64	65.75	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	43.82	43.82	32.88			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)					2,804	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)					2,804	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)					2,804	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)					87.63	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					68,351	22.00
23.00	Total salary equivalency (see instructions)					68,351	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)					920	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)					920	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)					72	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					992	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)					992	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: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/29/2024 11:18 am

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	87.64	65.75	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)	68,351		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	992		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)	69,343		63.00
64.00	Total cost of outside supplier services (from your records)	2,080		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	920		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	72		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	992		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	72		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	72		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: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/29/2024 11:18 am

		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	933,540	933,540				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	627,707		627,707			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,020,088	39,371	28,154	4,087,613		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,265,542	238,262	170,378	617,828	7,292,010	5.00
6.00	00600	MAINTENANCE & REPAIRS	864,708	161,176	115,255	171,793	1,312,932	6.00
7.00	00700	OPERATION OF PLANT	650,673	0	0	0	650,673	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	39,731	7,109	5,084	0	51,924	8.00
9.00	00900	HOUSEKEEPING	609,612	15,286	10,931	150,457	786,286	9.00
10.00	01000	DIETARY	313,844	11,254	8,047	76,917	410,062	10.00
11.00	01100	CAFETERIA	0	4,128	2,952	0	7,080	11.00
13.00	01300	NURSING ADMINISTRATION	231,524	1,387	992	71,402	305,305	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	368,331	10,002	7,153	0	385,486	16.00
17.00	01700	SOCIAL SERVICE	309,074	996	712	39,306	350,088	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	216,519	0	0	69,549	286,068	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,745,507	100,078	71,565	533,121	2,450,271	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	730,904	43,069	30,799	208,955	1,013,727	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,326,431	27,138	19,406	303,395	1,676,370	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	113,289	3,507	2,508	26,634	145,938	54.01
60.00	06000	LABORATORY	1,851,792	15,900	11,370	141,027	2,020,089	60.00
65.00	06500	RESPIRATORY THERAPY	87,947	9,253	6,617	16,780	120,597	65.00
65.01	03610	SLEEP LAB	17,661	669	479	0	18,809	65.01
66.00	06600	PHYSICAL THERAPY	64,433	0	0	0	64,433	66.00
67.00	06700	OCCUPATIONAL THERAPY	70,857	0	0	19,687	90,544	67.00
68.00	06800	SPEECH PATHOLOGY	29,628	0	0	8,849	38,477	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	459,994	6,806	4,867	18,921	490,588	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,083,547	10,799	7,722	142,608	3,244,676	73.00
73.01	03480	ONCOLOGY	64,397	24,651	17,628	19,418	126,094	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,631,871	46,305	33,113	800,107	3,511,396	88.00
91.00	09100	EMERGENCY	3,804,048	40,168	28,724	484,158	4,357,098	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,533,199	817,314	584,456	3,920,912	31,207,021	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	33,175	24,786	17,725	10,120	85,806	192.00
192.01	19201	XPRESS CARE	506,819	0	11,039	143,491	661,349	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	11,764	0	0	11,764	193.01
193.02	19302	LEASED SPACE	0	16,753	0	0	16,753	193.02
193.03	19303	UNUSED SPACE	0	5,547	0	0	5,547	193.03
193.04	19304	WELLNESS	45,709	20,260	14,487	9,052	89,508	193.04
193.05	19305	RETAIL PHARMACY	20,813	37,116	0	4,038	61,967	193.05
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)	32,139,715	933,540	627,707	4,087,613	32,139,715	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/29/2024 11:18 am

		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	7,292,010					5.00
6.00	00600	MAINTENANCE & REPAIRS	385,304	1,698,236				6.00
7.00	00700	OPERATION OF PLANT	190,952	0	841,625			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,238	23,925	12,094	103,181		8.00
9.00	00900	HOUSEKEEPING	230,750	51,444	26,005	0	1,094,485	9.00
10.00	01000	DIETARY	120,340	37,872	19,144	0	25,541	10.00
11.00	01100	CAFETERIA	2,078	13,894	7,023	0	9,370	11.00
13.00	01300	NURSING ADMINISTRATION	89,597	4,667	2,359	0	3,147	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	113,128	33,661	17,016	0	22,702	16.00
17.00	01700	SOCIAL SERVICE	102,740	3,353	1,695	0	2,261	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	83,952	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	719,076	336,798	170,248	103,181	227,144	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	297,496	144,944	73,268	0	97,752	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	491,961	91,328	46,166	0	61,593	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	42,828	11,802	5,966	0	7,959	54.01
60.00	06000	LABORATORY	592,831	53,509	27,049	0	36,087	60.00
65.00	06500	RESPIRATORY THERAPY	35,391	31,140	15,741	0	21,001	65.00
65.01	03610	SLEEP LAB	5,520	2,253	1,139	0	1,519	65.01
66.00	06600	PHYSICAL THERAPY	18,909	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,572	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,292	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	143,972	22,906	11,579	0	15,448	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	952,209	36,343	18,371	0	24,510	73.00
73.01	03480	ONCOLOGY	37,005	82,959	41,936	0	55,949	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,030,482	155,833	78,773	0	105,096	88.00
91.00	09100	EMERGENCY	1,278,672	135,181	68,333	0	91,168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,018,295	1,273,812	643,905	103,181	808,247	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	25,181	83,415	42,166	0	56,256	192.00
192.01	19201	XPRESS CARE	194,085	51,953	0	0	35,038	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	3,452	39,589	20,012	0	26,699	193.01
193.02	19302	LEASED SPACE	4,916	56,379	28,499	0	38,023	193.02
193.03	19303	UNUSED SPACE	1,628	0	9,437	0	0	193.03
193.04	19304	WELLNESS	26,268	68,180	34,465	0	45,982	193.04
193.05	19305	RETAIL PHARMACY	18,185	124,908	63,141	0	84,240	193.05
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)	7,292,010	1,698,236	841,625	103,181	1,094,485	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/29/2024 11:18 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	612,959					10.00
11.00	01100	CAFETERIA	0	39,445				11.00
13.00	01300	NURSING ADMINISTRATION	0	966	406,041			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	571,993		16.00
17.00	01700	SOCIAL SERVICE	0	532	0	0	460,669	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	941	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	612,959	7,216	166,315	27,820	460,669	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,828	51,678	38,780	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,101	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,107	10,212	193,586	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	361	0	6,702	0	54.01
60.00	06000	LABORATORY	0	1,909	0	103,854	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	227	0	4,535	0	65.00
65.01	03610	SLEEP LAB	0	0	0	1,828	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	1,964	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	266	0	2,963	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	120	0	581	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	256	0	22,111	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,930	0	75,837	0	73.00
73.01	03480	ONCOLOGY	0	263	6,141	2,452	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	10,832	59,591	22,656	0	88.00
91.00	09100	EMERGENCY	0	6,554	108,003	63,223	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	612,959	39,308	401,940	571,993	460,669	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	137	3,975	0	0	192.00
192.01	19201	XPRESS CARE	0	0	126	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	0	0	0	0	193.01
193.02	19302	LEASED SPACE	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	WELLNESS	0	0	0	0	0	193.04
193.05	19305	RETAIL PHARMACY	0	0	0	0	0	193.05
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)	612,959	39,445	406,041	571,993	460,669	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/29/2024 11:18 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	370,961					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	5,281,697	0	5,281,697		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,720,473	0	1,720,473		50.00
53.00	05300	ANESTHESIOLOGY	370,961	374,062	0	374,062		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,575,323	0	2,575,323		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	221,556	0	221,556		54.01
60.00	06000	LABORATORY	0	2,835,328	0	2,835,328		60.00
65.00	06500	RESPIRATORY THERAPY	0	228,632	0	228,632		65.00
65.01	03610	SLEEP LAB	0	31,068	0	31,068		65.01
66.00	06600	PHYSICAL THERAPY	0	85,306	0	85,306		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	120,345	0	120,345		67.00
68.00	06800	SPEECH PATHOLOGY	0	50,470	0	50,470		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	706,860	0	706,860		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,353,876	0	4,353,876		73.00
73.01	03480	ONCOLOGY	0	352,799	0	352,799		73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,974,659	0	4,974,659		88.00
91.00	09100	EMERGENCY	0	6,108,232	0	6,108,232		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	370,961	30,020,686	0	30,020,686		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	296,936	0	296,936		192.00
192.01	19201	XPRESS CARE	0	942,551	0	942,551		192.01
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	RENAL	0	101,516	0	101,516		193.01
193.02	19302	LEASED SPACE	0	144,570	0	144,570		193.02
193.03	19303	UNUSED SPACE	0	16,612	0	16,612		193.03
193.04	19304	WELLNESS	0	264,403	0	264,403		193.04
193.05	19305	RETAIL PHARMACY	0	352,441	0	352,441		193.05
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	370,961	32,139,715	0	32,139,715		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/29/2024 11:18 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	39,371	28,154	67,525	67,525	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,419	238,262	170,378	432,059	10,206	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	161,176	115,255	276,431	2,838	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,109	5,084	12,193	0	8.00
9.00	00900	HOUSEKEEPING	0	15,286	10,931	26,217	2,485	9.00
10.00	01000	DIETARY	0	11,254	8,047	19,301	1,271	10.00
11.00	01100	CAFETERIA	0	4,128	2,952	7,080	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,387	992	2,379	1,179	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,002	7,153	17,155	0	16.00
17.00	01700	SOCIAL SERVICE	0	996	712	1,708	649	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	1,149	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,485	100,078	71,565	178,128	8,806	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	43,069	30,799	73,868	3,452	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	27,138	19,406	46,544	5,012	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	3,507	2,508	6,015	440	54.01
60.00	06000	LABORATORY	0	15,900	11,370	27,270	2,330	60.00
65.00	06500	RESPIRATORY THERAPY	17,472	9,253	6,617	33,342	277	65.00
65.01	03610	SLEEP LAB	0	669	479	1,148	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	325	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	146	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,806	4,867	11,673	313	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,496	10,799	7,722	27,017	2,356	73.00
73.01	03480	ONCOLOGY	0	24,651	17,628	42,279	321	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	46,305	33,113	79,418	13,218	88.00
91.00	09100	EMERGENCY	0	40,168	28,724	68,892	7,998	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,872	817,314	584,456	1,457,642	64,771	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	24,786	17,725	42,511	167	192.00
192.01	19201	XPRESS CARE	28,409	0	11,039	39,448	2,370	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	11,764	0	11,764	0	193.01
193.02	19302	LEASED SPACE	0	16,753	0	16,753	0	193.02
193.03	19303	UNUSED SPACE	0	5,547	0	5,547	0	193.03
193.04	19304	WELLNESS	0	20,260	14,487	34,747	150	193.04
193.05	19305	RETAIL PHARMACY	0	37,116	0	37,116	67	193.05
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)	84,281	933,540	627,707	1,645,528	67,525	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/29/2024 11:18 am

		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	442,265					5.00
6.00	00600	MAINTENANCE & REPAIRS	23,369	302,638				6.00
7.00	00700	OPERATION OF PLANT	11,581	0	11,581			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	924	4,264	166	17,547		8.00
9.00	00900	HOUSEKEEPING	13,995	9,168	358	0	52,223	9.00
10.00	01000	DIETARY	7,299	6,749	263	0	1,219	10.00
11.00	01100	CAFETERIA	126	2,476	97	0	447	11.00
13.00	01300	NURSING ADMINISTRATION	5,434	832	32	0	150	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,861	5,999	234	0	1,083	16.00
17.00	01700	SOCIAL SERVICE	6,231	597	23	0	108	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	5,092	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,612	60,019	2,345	17,547	10,837	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,043	25,830	1,008	0	4,664	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,838	16,275	635	0	2,939	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	2,598	2,103	82	0	380	54.01
60.00	06000	LABORATORY	35,956	9,536	372	0	1,722	60.00
65.00	06500	RESPIRATORY THERAPY	2,147	5,549	217	0	1,002	65.00
65.01	03610	SLEEP LAB	335	402	16	0	73	65.01
66.00	06600	PHYSICAL THERAPY	1,147	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,612	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	685	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,732	4,082	159	0	737	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,752	6,477	253	0	1,170	73.00
73.01	03480	ONCOLOGY	2,244	14,784	577	0	2,670	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	62,499	27,771	1,084	0	5,015	88.00
91.00	09100	EMERGENCY	77,553	24,090	940	0	4,350	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	425,665	227,003	8,861	17,547	38,566	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	1,527	14,865	580	0	2,684	192.00
192.01	19201	XPRESS CARE	11,771	9,258	0	0	1,672	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	209	7,055	275	0	1,274	193.01
193.02	19302	LEASED SPACE	298	10,047	392	0	1,814	193.02
193.03	19303	UNUSED SPACE	99	0	130	0	0	193.03
193.04	19304	WELLNESS	1,593	12,150	474	0	2,194	193.04
193.05	19305	RETAIL PHARMACY	1,103	22,260	869	0	4,019	193.05
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)	442,265	302,638	11,581	17,547	52,223	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/29/2024 11:18 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	36,102					10.00
11.00	01100	CAFETERIA	0	10,226				11.00
13.00	01300	NURSING ADMINISTRATION	0	251	10,257			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	31,332		16.00
17.00	01700	SOCIAL SERVICE	0	138	0	0	9,454	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	244	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,102	1,870	4,203	1,524	9,454	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	733	1,305	2,124	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	170	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,064	258	10,605	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	93	0	367	0	54.01
60.00	06000	LABORATORY	0	495	0	5,689	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	59	0	248	0	65.00
65.01	03610	SLEEP LAB	0	0	0	100	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	108	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	69	0	162	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	31	0	32	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	66	0	1,211	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	500	0	4,154	0	73.00
73.01	03480	ONCOLOGY	0	68	155	134	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,810	1,505	1,241	0	88.00
91.00	09100	EMERGENCY	0	1,699	2,728	3,463	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,102	10,190	10,154	31,332	9,454	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	36	100	0	0	192.00
192.01	19201	XPRESS CARE	0	0	3	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	0	0	0	0	193.01
193.02	19302	LEASED SPACE	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	WELLNESS	0	0	0	0	0	193.04
193.05	19305	RETAIL PHARMACY	0	0	0	0	0	193.05
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)	36,102	10,226	10,257	31,332	9,454	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/29/2024 11:18 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	6,485					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		374,447	0	374,447		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		131,027	0	131,027		50.00
53.00	05300	ANESTHESIOLOGY		170	0	170		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		113,170	0	113,170		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC		12,078	0	12,078		54.01
60.00	06000	LABORATORY		83,370	0	83,370		60.00
65.00	06500	RESPIRATORY THERAPY		42,841	0	42,841		65.00
65.01	03610	SLEEP LAB		2,074	0	2,074		65.01
66.00	06600	PHYSICAL THERAPY		1,255	0	1,255		66.00
67.00	06700	OCCUPATIONAL THERAPY		2,168	0	2,168		67.00
68.00	06800	SPEECH PATHOLOGY		894	0	894		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		26,973	0	26,973		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		99,679	0	99,679		73.00
73.01	03480	ONCOLOGY		63,232	0	63,232		73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		194,561	0	194,561		88.00
91.00	09100	EMERGENCY		191,713	0	191,713		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,339,652	0	1,339,652		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		62,470	0	62,470		192.00
192.01	19201	XPRESS CARE		64,522	0	64,522		192.01
193.00	19300	NONPAID WORKERS		0	0	0		193.00
193.01	19301	RENAL		20,577	0	20,577		193.01
193.02	19302	LEASED SPACE		29,304	0	29,304		193.02
193.03	19303	UNUSED SPACE		5,776	0	5,776		193.03
193.04	19304	WELLNESS		51,308	0	51,308		193.04
193.05	19305	RETAIL PHARMACY		65,434	0	65,434		193.05
200.00		Cross Foot Adjustments	6,485	6,485	0	6,485		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	6,485	1,645,528	0	1,645,528		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/29/2024 11:18 am

		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	117,133					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		110,139				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,940	4,940	12,725,424			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	29,895	29,895	1,923,403	-7,292,010	24,847,705	5.00
6.00	00600	MAINTENANCE & REPAIRS	20,223	20,223	534,822	0	1,312,932	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	650,673	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	892	892	0	0	51,924	8.00
9.00	00900	HOUSEKEEPING	1,918	1,918	468,398	0	786,286	9.00
10.00	01000	DIETARY	1,412	1,412	239,455	0	410,062	10.00
11.00	01100	CAFETERIA	518	518	0	0	7,080	11.00
13.00	01300	NURSING ADMINISTRATION	174	174	222,286	0	305,305	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,255	1,255	0	0	385,486	16.00
17.00	01700	SOCIAL SERVICE	125	125	122,367	0	350,088	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	216,519	0	286,068	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,557	12,557	1,659,696	0	2,450,271	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,404	5,404	650,512	0	1,013,727	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,405	3,405	944,519	0	1,676,370	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	440	440	82,917	0	145,938	54.01
60.00	06000	LABORATORY	1,995	1,995	439,042	0	2,020,089	60.00
65.00	06500	RESPIRATORY THERAPY	1,161	1,161	52,238	0	120,597	65.00
65.01	03610	SLEEP LAB	84	84	0	0	18,809	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	64,433	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	61,289	0	90,544	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	27,548	0	38,477	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	854	854	58,904	0	490,588	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,355	1,355	443,964	0	3,244,676	73.00
73.01	03480	ONCOLOGY	3,093	3,093	60,453	0	126,094	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,810	5,810	2,490,855	0	3,511,396	88.00
91.00	09100	EMERGENCY	5,040	5,040	1,507,267	0	4,357,098	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	102,550	102,550	12,206,454	-7,292,010	23,915,011	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,110	3,110	31,505	0	85,806	192.00
192.01	19201	XPRESS CARE	0	1,937	446,713	0	661,349	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	1,476	0	0	0	11,764	193.01
193.02	19302	LEASED SPACE	2,102	0	0	0	16,753	193.02
193.03	19303	UNUSED SPACE	696	0	0	0	5,547	193.03
193.04	19304	WELLNESS	2,542	2,542	28,181	0	89,508	193.04
193.05	19305	RETAIL PHARMACY	4,657	0	12,571	0	61,967	193.05
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)	933,540	627,707	4,087,613		7,292,010	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.969915	5.699226	0.321216		0.293468	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			67,525		442,265	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.005306		0.017799	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: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/29/2024 11:18 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	63,316					6.00
7.00	00700	OPERATION OF PLANT	0	62,075				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	892	892	1,906			8.00
9.00	00900	HOUSEKEEPING	1,918	1,918	0	60,506		9.00
10.00	01000	DIETARY	1,412	1,412	0	1,412	1,906	10.00
11.00	01100	CAFETERIA	518	518	0	518	0	11.00
13.00	01300	NURSING ADMINISTRATION	174	174	0	174	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,255	1,255	0	1,255	0	16.00
17.00	01700	SOCIAL SERVICE	125	125	0	125	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,557	12,557	1,906	12,557	1,906	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,404	5,404	0	5,404	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,405	3,405	0	3,405	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	440	440	0	440	0	54.01
60.00	06000	LABORATORY	1,995	1,995	0	1,995	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,161	1,161	0	1,161	0	65.00
65.01	03610	SLEEP LAB	84	84	0	84	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	854	854	0	854	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,355	1,355	0	1,355	0	73.00
73.01	03480	ONCOLOGY	3,093	3,093	0	3,093	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,810	5,810	0	5,810	0	88.00
91.00	09100	EMERGENCY	5,040	5,040	0	5,040	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,492	47,492	1,906	44,682	1,906	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,110	3,110	0	3,110	0	192.00
192.01	19201	XPRESS CARE	1,937	0	0	1,937	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	1,476	1,476	0	1,476	0	193.01
193.02	19302	LEASED SPACE	2,102	2,102	0	2,102	0	193.02
193.03	19303	UNUSED SPACE	0	696	0	0	0	193.03
193.04	19304	WELLNESS	2,542	2,542	0	2,542	0	193.04
193.05	19305	RETAIL PHARMACY	4,657	4,657	0	4,657	0	193.05
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)	1,698,236	841,625	103,181	1,094,485	612,959	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.821593	13.558196	54.134837	18.088867	321.594439	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	302,638	11,581	17,547	52,223	36,102	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.779803	0.186565	9.206191	0.863104	18.941238	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: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/29/2024 11:18 am

		Cost Center Description	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (TOTAL CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	9,071,881					11.00
13.00	01300	NURSING ADMINISTRATION	222,286	3,309,602				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	78,526,611			16.00
17.00	01700	SOCIAL SERVICE	122,367	0	0	1,906		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	216,519	0	0	0	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,659,696	1,355,630	3,819,395	1,906	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	650,512	421,221	5,324,012	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	425,675	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	944,519	83,236	26,576,272	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	82,917	0	920,075	0	0	54.01
60.00	06000	LABORATORY	439,042	0	14,257,796	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	52,238	0	622,558	0	0	65.00
65.01	03610	SLEEP LAB	0	0	250,900	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	269,600	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	61,289	0	406,766	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	27,548	0	79,807	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	58,904	0	3,035,594	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	443,964	0	10,411,480	0	0	73.00
73.01	03480	ONCOLOGY	60,453	50,054	336,595	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,490,855	485,719	3,110,338	0	0	88.00
91.00	09100	EMERGENCY	1,507,267	880,319	8,679,748	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,040,376	3,276,179	78,526,611	1,906	100	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	31,505	32,396	0	0	0	192.00
192.01	19201	XPRESS CARE	0	1,027	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	RENAL	0	0	0	0	0	193.01
193.02	19302	LEASED SPACE	0	0	0	0	0	193.02
193.03	19303	UNUSED SPACE	0	0	0	0	0	193.03
193.04	19304	WELLNESS	0	0	0	0	0	193.04
193.05	19305	RETAIL PHARMACY	0	0	0	0	0	193.05
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)	39,445	406,041	571,993	460,669	370,961	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.004348	0.122686	0.007284	241.694124	3,709.610000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,226	10,257	31,332	9,454	6,485	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001127	0.003099	0.000399	4.960126	64.850000	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: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/29/2024 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,281,697		5,281,697	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,720,473		1,720,473	0	0	50.00
53.00	05300	ANESTHESIOLOGY	374,062		374,062	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,575,323		2,575,323	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	221,556		221,556	0	0	54.01
60.00	06000	LABORATORY	2,835,328		2,835,328	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	228,632	0	228,632	0	0	65.00
65.01	03610	SLEEP LAB	31,068	0	31,068	0	0	65.01
66.00	06600	PHYSICAL THERAPY	85,306	0	85,306	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	120,345	0	120,345	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	50,470	0	50,470	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	706,860		706,860	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,353,876		4,353,876	0	0	73.00
73.01	03480	ONCOLOGY	352,799		352,799	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,974,659		4,974,659	0	0	88.00
91.00	09100	EMERGENCY	6,108,232		6,108,232	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	556,931		556,931		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	30,577,617	0	30,577,617	0	0	200.00
201.00		Less Observation Beds	556,931		556,931		0	201.00
202.00		Total (see instructions)	30,020,686	0	30,020,686	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/29/2024 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,003,233		3,003,233			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,538	5,306,474	5,324,012	0.323153	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	425,675	425,675	0.878750	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,144,531	25,431,741	26,576,272	0.096903	0.000000	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	920,075	920,075	0.240802	0.000000	54.01
60.00	06000	LABORATORY	1,669,244	12,588,552	14,257,796	0.198862	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	301,179	321,379	622,558	0.367246	0.000000	65.00
65.01	03610	SLEEP LAB	2,000	248,900	250,900	0.123826	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	262,133	7,467	269,600	0.316417	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	394,903	11,863	406,766	0.295858	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	48,632	31,175	79,807	0.632401	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	522,996	2,512,598	3,035,594	0.232857	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,325,297	9,086,183	10,411,480	0.418180	0.000000	73.00
73.01	03480	ONCOLOGY	0	336,595	336,595	1.048141	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,110,338	3,110,338			88.00
91.00	09100	EMERGENCY	4,007	8,675,741	8,679,748	0.703734	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	816,162	816,162	0.682378	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	8,695,693	69,830,918	78,526,611			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,695,693	69,830,918	78,526,611			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/29/2024 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.000000	54.01
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
65.01	03610	SLEEP LAB	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
73.01	03480	ONCOLOGY	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/29/2024 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	131,027	5,324,012	0.024611	6,412	158	50.00
53.00	05300	ANESTHESIOLOGY	170	425,675	0.000399	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	113,170	26,576,272	0.004258	535,452	2,280	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	12,078	920,075	0.013127	0	0	54.01
60.00	06000	LABORATORY	83,370	14,257,796	0.005847	766,022	4,479	60.00
65.00	06500	RESPIRATORY THERAPY	42,841	622,558	0.068814	138,336	9,519	65.00
65.01	03610	SLEEP LAB	2,074	250,900	0.008266	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,255	269,600	0.004655	23,905	111	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,168	406,766	0.005330	60,354	322	67.00
68.00	06800	SPEECH PATHOLOGY	894	79,807	0.011202	17,443	195	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,973	3,035,594	0.008886	224,825	1,998	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	99,679	10,411,480	0.009574	462,285	4,426	73.00
73.01	03480	ONCOLOGY	63,232	336,595	0.187858	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	194,561	3,110,338	0.062553	0	0	88.00
91.00	09100	EMERGENCY	191,713	8,679,748	0.022087	3,967	88	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	39,484	816,162	0.048378	0	0	92.00
200.00		Total (lines 50 through 199)	1,004,689	75,523,378		2,239,001	23,576	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/29/2024 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	370,961	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	370,961	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/29/2024 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	5,324,012	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	370,961	0	425,675	0.871465	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	26,576,272	0.000000	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	920,075	0.000000	54.01
60.00	06000	LABORATORY	0	0	0	14,257,796	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	622,558	0.000000	65.00
65.01	03610	SLEEP LAB	0	0	0	250,900	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	269,600	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	406,766	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	79,807	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,035,594	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,411,480	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	336,595	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,110,338	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	8,679,748	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	816,162	0.000000	92.00
200.00		Total (lines 50 through 199)	0	370,961	0	75,523,378		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/29/2024 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	6,412	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	535,452	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.000000	0	0	0	0	54.01
60.00	06000	LABORATORY	0.000000	766,022	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	138,336	0	0	0	65.00
65.01	03610	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	23,905	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	60,354	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	17,443	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	224,825	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	462,285	0	0	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	3,967	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)		2,239,001	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/29/2024 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.323153	0	1,389,566	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.878750	0	117,607	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.096903	0	8,073,498	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.240802	0	339,430	0	0	54.01
60.00	06000	LABORATORY	0.198862	0	3,721,715	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.367246	0	113,527	0	0	65.00
65.01	03610	SLEEP LAB	0.123826	0	56,761	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.316417	0	2,184	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.295858	0	3,068	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.632401	0	2,971	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.232857	0	718,534	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.418180	0	5,252,048	8,721	0	73.00
73.01	03480	ONCOLOGY	1.048141	0	116,282	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	0.703734	0	2,240,808	1,553	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.682378	0	327,602	0	0	92.00
200.00		Subtotal (see instructions)		0	22,475,601	10,274	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	22,475,601	10,274	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/29/2024 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	449,042	0		50.00
53.00	05300	ANESTHESIOLOGY	103,347	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	782,346	0		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	81,735	0		54.01
60.00	06000	LABORATORY	740,108	0		60.00
65.00	06500	RESPIRATORY THERAPY	41,692	0		65.00
65.01	03610	SLEEP LAB	7,028	0		65.01
66.00	06600	PHYSICAL THERAPY	691	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	908	0		67.00
68.00	06800	SPEECH PATHOLOGY	1,879	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	167,316	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,196,301	3,647		73.00
73.01	03480	ONCOLOGY	121,880	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	1,576,933	1,093		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	223,548	0		92.00
200.00		Subtotal (see instructions)	6,494,754	4,740		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,494,754	4,740		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315 | Component CCN: 14-Z315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V | Date/Time Prepared: 2/29/2024 11:18 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.323153	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.878750	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.096903	0	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.240802	0	0	0	0	54.01
60.00	06000	LABORATORY	0.198862	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.367246	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0.123826	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.316417	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.295858	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.632401	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.232857	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.418180	0	0	75	0	73.00
73.01	03480	ONCOLOGY	1.048141	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	0.703734	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.682378	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	75	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	75	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1315 | Component CCN: 14-Z315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V | Date/Time Prepared: 2/29/2024 11:18 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0		54.01
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	03610	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	31		73.00
73.01	03480	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	31		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	31		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/29/2024 11:18 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,031	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,283	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)	1,091	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	131	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)	392	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	56	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)	169	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	651	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)	131	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)	392	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	187.82	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	192.61	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,281,697	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)	10,518	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)	32,551	25.00
26.00	Total swing-bed cost (see instructions)	1,560,125	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,721,572	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,721,572	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)	2,900.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,888,343	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,888,343	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/29/2024 11:18 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	542,008	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)	2,430,351	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)	379,989	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,137,067	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	1,517,056	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)	192	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,900.68	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	556,931	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/29/2024 11:18 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	374,447	5,281,697	0.070895	556,931	39,484	90.00
91.00	Nursing Program cost	0	5,281,697	0.000000	556,931	0	91.00
92.00	Allied health cost	0	5,281,697	0.000000	556,931	0	92.00
93.00	All other Medical Education	0	5,281,697	0.000000	556,931	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/29/2024 11:18 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,279,284		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.323153	6,412	2,072	50.00
53.00	05300	ANESTHESIOLOGY	0.878750	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.096903	535,452	51,887	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.240802	0	0	54.01
60.00	06000	LABORATORY	0.198862	766,022	152,333	60.00
65.00	06500	RESPIRATORY THERAPY	0.367246	138,336	50,803	65.00
65.01	03610	SLEEP LAB	0.123826	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.316417	23,905	7,564	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.295858	60,354	17,856	67.00
68.00	06800	SPEECH PATHOLOGY	0.632401	17,443	11,031	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.232857	224,825	52,352	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.418180	462,285	193,318	73.00
73.01	03480	ONCOLOGY	1.048141	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.703734	3,967	2,792	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.682378	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,239,001	542,008	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,239,001		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1315 | Component CCN: 14-Z315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/29/2024 11:18 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.323153	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.878750	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.096903	107,361	10,404	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.240802	0	0	54.01
60.00	06000	LABORATORY	0.198862	157,555	31,332	60.00
65.00	06500	RESPIRATORY THERAPY	0.367246	62,733	23,038	65.00
65.01	03610	SLEEP LAB	0.123826	1,728	214	65.01
66.00	06600	PHYSICAL THERAPY	0.316417	147,744	46,749	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.295858	203,099	60,088	67.00
68.00	06800	SPEECH PATHOLOGY	0.632401	13,441	8,500	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.232857	88,111	20,517	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.418180	274,775	114,905	73.00
73.01	03480	ONCOLOGY	1.048141	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.703734	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.682378	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,056,547	315,747	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,056,547		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1315	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/29/2024 11:18 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,499,494	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)	6,499,494	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)	6,564,489	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)	31,505	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,715,884	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,817,100	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	2,817,100	30.00
31.00	Primary payer payments	1,954	31.00
32.00	Subtotal (line 30 minus line 31)	2,815,146	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)	394,656	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	256,526	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	392,606	36.00
37.00	Subtotal (see instructions)	3,071,672	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,071,672	40.00
40.01	Sequestration adjustment (see instructions)	61,433	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,439,108	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)	-428,869	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1315	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/29/2024 11:18 am
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/29/2024 11:18 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,871,195		3,168,636	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	05/17/2023	322,627	05/17/2023	175,055	3.01
3.02		09/12/2023	195,491	09/12/2023	95,417	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		518,118		270,472	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)		2,389,313		3,439,108	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		174,895		428,869	6.02
7.00	Total Medicare program liability (see instructions)		2,214,418		3,010,239	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: 14-1315 | Component CCN: 14-Z315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/29/2024 11:18 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,400,012		74	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	05/17/2023	335,339		0	3.01
3.02		09/12/2023	48,863		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		384,202		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)		1,784,214		74	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		17,213		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		44	6.02
7.00	Total Medicare program liability (see instructions)		1,801,427		30	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: 14-1315	Period: From 10/01/2022 To 09/30/2023	Worksheet E-1 Part II Date/Time Prepared: 2/29/2024 11:18 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-1315 | Component CCN: 14-Z315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-2 | Date/Time Prepared: 2/29/2024 11:18 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,532,227	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)	318,904	31	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	523	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)	1,851,131	31	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,851,131	31	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)	1,851,131	31	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	12,940	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,838,191	31	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,838,191	31	19.00
19.01	Sequestration adjustment (see instructions)	36,764	1	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	1,784,214	74	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)	17,213	-44	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: 14-1315	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part V Date/Time Prepared: 2/29/2024 11:18 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,430,351	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)	2,430,351	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,454,655	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)	2,454,655	19.00
20.00	Deductibles (exclude professional component)	230,328	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,224,327	22.00
23.00	Coinsurance	778	23.00
24.00	Subtotal (line 22 minus line 23)	2,223,549	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	55,478	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	36,061	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	55,478	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,259,610	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)	2,259,610	30.00
30.01	Sequestration adjustment (see instructions)	45,192	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,389,313	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)	-174,895	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G | Date/Time Prepared: 2/29/2024 11:18 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	11,569,169	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	14,554,586	0	0	0	4.00
5.00	Other receivable	636,820	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,355,000	0	0	0	6.00
7.00	Inventory	1,058,023	0	0	0	7.00
8.00	Prepaid expenses	139,603	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	18,603,201	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	287,556	0	0	0	12.00
13.00	Land improvements	618,814	0	0	0	13.00
14.00	Accumulated depreciation	-510,361	0	0	0	14.00
15.00	Buildings	20,754,914	0	0	0	15.00
16.00	Accumulated depreciation	-9,557,090	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	9,598,828	0	0	0	23.00
24.00	Accumulated depreciation	-6,638,594	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	14,554,067	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	12,197,494	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	353,407	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	12,550,901	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	45,708,169	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,371,192	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,600,191	0	0	0	38.00
39.00	Payroll taxes payable	61,661	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	230,291	0	0	0	43.00
44.00	Other current liabilities	3,015,267	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,278,602	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	1,277,850	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	1,546,767	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,824,617	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	9,103,219	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	36,604,950				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)	36,604,950	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	45,708,169	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-1 | Date/Time Prepared: 2/29/2024 11:18 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		31,891,517		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,748,826				2.00
3.00	Total (sum of line 1 and line 2)		36,640,343		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)		36,640,343		0		11.00
12.00	ADOPTION OF ASC 842	35,393		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)		35,393		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		36,604,950		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	ADOPTION OF ASC 842		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: 14-1315 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 2/29/2024 11:18 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,212,191		2,212,191	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	570,356		570,356	5.00
6.00	Swing bed - NF	318,440		318,440	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)	3,100,987		3,100,987	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)	3,100,987		3,100,987	17.00
18.00	Ancillary services	6,310,026	72,607,652	78,917,678	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	3,110,338	3,110,338	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRIVATE OFFICE	0	477,173	477,173	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,411,013	76,195,163	85,606,176	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		34,533,857		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)		34,533,857		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1315	Period: From 10/01/2022 To 09/30/2023	Worksheet G-3 Date/Time Prepared: 2/29/2024 11:18 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	85,606,176	1.00
2.00	Less contractual allowances and discounts on patients' accounts	49,853,974	2.00
3.00	Net patient revenues (line 1 minus line 2)	35,752,202	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	34,533,857	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,218,345	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	5,010	6.00
7.00	Income from investments	1,217,811	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	13,583	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	155,491	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	2,122,947	24.00
24.50	COVID-19 PHE Funding	15,639	24.50
25.00	Total other income (sum of lines 6-24)	3,530,481	25.00
26.00	Total (line 5 plus line 25)	4,748,826	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,748,826	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1315 | Component CCN: 14-3482 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/29/2024 11:18 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,056,857	0	1,056,857	0	1,056,857	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	403,170	0	403,170	0	403,170	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	38,267	0	38,267	0	38,267	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	460,995	0	460,995	0	460,995	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,959,289	0	1,959,289	0	1,959,289	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	1,483	1,483	0	1,483	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	1,483	1,483	0	1,483	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	77,104	77,104	0	77,104	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	77,104	77,104	0	77,104	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,959,289	78,587	2,037,876	0	2,037,876	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	52,236	2,148	54,384	0	54,384	25.01
25.02	Chronic Care Management	21,682	1,024	22,706	0	22,706	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)	73,918	3,172	77,090	0	77,090	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	327	327	0	327	29.00
30.00	Administrative Costs	457,648	47,585	505,233	0	505,233	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	457,648	47,912	505,560	0	505,560	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,490,855	129,671	2,620,526	0	2,620,526	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1315 | Component CCN: 14-3482 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/29/2024 11:18 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,056,857		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	403,170		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	38,267		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	460,995		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,959,289		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	1,483		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	1,483		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	-763	76,341		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	-763	76,341		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-763	2,037,113		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	54,384		25.01
25.02	Chronic Care Management	0	22,706		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	77,090		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-182	145		29.00
30.00	Administrative Costs	12,290	517,523		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	12,108	517,668		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	11,345	2,631,871		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1315 | Component CCN: 14-3482 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/29/2024 11:18 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	3.40	6,083	4,200	14,280		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	3.02	6,693	2,100	6,342		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.42	12,776		20,622	20,622	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	0.48	1,305			1,305	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	6.90	14,081			21,927	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,037,113	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					77,090	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,114,203	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.963537	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					517,668	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,342,788	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,860,456	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,860,456	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,756,155	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,793,268	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1315 Component CCN: 14-3482	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/29/2024 11:18 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			4,793,268	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			136,637	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			4,656,631	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			21,927	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)			21,927	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			212.37	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)	230.93	230.93		8.00
9.00	Rate for Program covered visits (see instructions)	212.37	212.37		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	629	1,923		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	133,581	408,388		11.00
12.00	Program covered visits for mental health services (from contractor records)	11	96		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	2,336	20,388		13.00
14.00	Limit adjustment for mental health services (see instructions)	2,336	20,388		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	564,693		16.00
16.01	Total program charges (see instructions)(from contractor's records)		556,011		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		88,191		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		89,568		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.)		340,287		16.04
16.05	Total program cost (see instructions)	0	429,855		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		49,766		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		83,064		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		429,855		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		35,152		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		465,007		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)		465,007		26.00
26.01	Sequestration adjustment (see instructions)		9,300		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		498,895		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)		-43,188		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: 14-1315 | Component CCN: 14-3482 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/29/2024 11:18 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,959,289	1,959,289	1,959,289	1,959,289	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000519	0.002144	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,017	4,201	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	29,455	23,397	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	30,472	27,598	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,037,113	2,037,113	2,037,113	2,037,113	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,756,155	2,756,155	2,756,155	2,756,155	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.014958	0.013548	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	41,227	37,340	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	71,699	64,938	0	0	10.00
11.00	Total number of injections/infusions (from your records)	155	641	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	462.57	101.31	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	30	210	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)	13,877	21,275	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)		136,637	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)		35,152	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1315 Component CCN: 14-3482	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/29/2024 11:18 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		479,048	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		05/17/2023	19,847	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		19,847	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		498,895	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		43,188	6.02
7.00	Total Medicare program liability (see instructions)		455,707	7.00

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