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: 14-1348	Period: From 07/01/2022 To 01/13/2023	Worksheet S Parts I-III Date/Time Prepared: 7/6/2023 3:25 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/6/2023 Time: 3:25 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RED BUD REGIONAL HOSPITAL (14-1348) for the cost reporting period beginning 07/01/2022 and ending 01/13/2023 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	Hank Kunath		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	Hank Kunath			2
3	Signatory Title	EVP 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	98,571	-461,732	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	71,229	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		1,783		0	10.00
200.00	TOTAL	0	169,800	-459,949	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: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet S-2 Part I | Date/Time Prepared: 7/6/2023 3:25 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: ST. CLEMENT BLVD	PO Box:			1.00
2.00	City: RED BUD	State: IL	Zip Code: 62278-	County: RANDOLPH	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	RED BUD REGIONAL HOSPITAL	141348	99914	1	07/01/2005	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	RED BUD HOSPITAL	14Z348	99914		08/10/2005	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	OLDER ADULT HEALTH CENTER	148514	99914		05/26/2011	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2022	01/13/2023	20.00
21.00	Type of Control (see instructions)	4		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet S-2 Part I | Date/Time Prepared: 7/6/2023 3:25 pm

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

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

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

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

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

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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: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet S-2 Part I Date/Time Prepared: 7/6/2023 3:25 pm

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

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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)?	N	68.00

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

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet S-2 Part I Date/Time Prepared: 7/6/2023 3:25 pm

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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.	N		108.00

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

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

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

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
113.00	Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.				113.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet S-2 Part I | Date/Time Prepared: 7/6/2023 3:25 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	95,690	45,711	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0776	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: QUORUM HEALTH	Contractor's Name: WPS	Contractor's Number: 52280	141.00
142.00	Street: 1573 MALLORY LANE SUITE 100	PO Box:		142.00
143.00	City: BRENTWOOD	State: TN	Zip Code: 37027	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: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet S-2 Part I Date/Time Prepared: 7/6/2023 3:25 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet S-2 Part II | Date/Time Prepared: 7/6/2023 3:25 pm

		Y/N	Date	
		1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

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

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

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	06/14/2023	Y	06/14/2023	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet S-2 Part II Date/Time Prepared: 7/6/2023 3:25 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				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.				Y	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			Y	12/31/2022	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.	HEATHER		MANGEOT		41.00
42.00	Enter the employer/company name of the cost report preparer	QUORUM HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-390-3353		HMANGEOT02@QHCUS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1348	Period: From 07/01/2022 To 01/13/2023	Worksheet S-2 Part II Date/Time Prepared: 7/6/2023 3:25 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, REIMBURSEMENT		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: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet S-3 Part I Date/Time Prepared: 7/6/2023 3:25 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	4,925	32,040.00	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	4,925	32,040.00	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	4,925	32,040.00	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: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet S-3 Part I | Date/Time Prepared: 7/6/2023 3:25 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	687	10	1,335			1.00
2.00	HMO and other (see instructions)	362	81				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,121	0	1,498			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	16			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,808	10	2,849			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)	1,808	10	2,849	0.00	124.39	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	2,895	0	9,724	0.00	37.57	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	161.96	27.00
28.00	Observation Bed Days		0	232			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet S-3 Part I | Date/Time Prepared: 7/6/2023 3:25 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	189	4	384	1.00
2.00	HMO and other (see instructions)			74	28		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	189	4	384	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: 14-1348 | Component CCN: 14-8514 | Period: From 07/01/2022 To 01/13/2023 | Worksheet S-8 | Date/Time Prepared: 7/6/2023 3:25 pm

			RHC I	Cost
			1.00	
	Clinic Address and Identification			
1.00	Street		325 SPRING STREET	1.00
		City	State	ZIP Code
		1.00	2.00	3.00
2.00	City, State, ZIP Code, County	RED BUD	IL	62278 2.00
				1.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00
		Grant Award		Date
		1.00		2.00
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00
			1.00	2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0 10.00

		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC	08:00	16:00	07:00	19:00	07:00 11.00

	1.00	2.00	
12.00 Have you received an approval for an exception to the productivity standard?	Y		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		RANDOLPH			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	19:00	07:00	19:00	07:00	19:00 11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1348
Component CCN: 14-8514

Period:
From 07/01/2022
To 01/13/2023

Worksheet S-8
Date/Time Prepared:
7/6/2023 3:25 pm

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	19:00	08:00	16:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1348	Period: From 07/01/2022 To 01/13/2023	Worksheet S-10 Date/Time Prepared: 7/6/2023 3:25 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.205705	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,793,640	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	535,775	5.00
6.00	Medicaid charges	9,811,364	6.00
7.00	Medicaid cost (line 1 times line 6)	2,018,247	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	481,602	0	481,602	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	99,068	0	99,068	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	99,068	0	99,068	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	895,935	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	170,337	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	262,056	27.01
28.00	Non-Medicare bad debt expense (see instructions)	633,879	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	222,111	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	321,179	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	321,179	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet A | Date/Time Prepared: 7/6/2023 3:25 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		175,862	175,862	68,268	244,130	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		572,701	572,701	10,746	583,447	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	98,580	27,208	125,788	923,936	1,049,724	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,035,863	15,377,725	16,413,588	-999,309	15,414,279	5.00
7.00	00700	OPERATION OF PLANT	136,186	687,388	823,574	-43,632	779,942	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	38,676	38,676	0	38,676	8.00
9.00	00900	HOUSEKEEPING	131,155	35,061	166,216	-9,746	156,470	9.00
10.00	01000	DIETARY	0	555,338	555,338	-290,263	265,075	10.00
11.00	01100	CAFETERIA	0	0	0	290,263	290,263	11.00
13.00	01300	NURSING ADMINISTRATION	248,019	88,171	336,190	-29,529	306,661	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	30,853	133,656	164,509	-56,819	107,690	14.00
15.00	01500	PHARMACY	223,484	763,117	986,601	-705,546	281,055	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	54,991	54,991	0	54,991	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,372,682	225,464	1,598,146	0	1,598,146	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	183,436	134,565	318,001	-511	317,490	50.00
53.00	05300	ANESTHESIOLOGY	0	194,222	194,222	-199	194,023	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	372,022	458,246	830,268	0	830,268	54.00
60.00	06000	LABORATORY	381,368	383,374	764,742	0	764,742	60.00
65.00	06500	RESPIRATORY THERAPY	180,143	45,196	225,339	-6,806	218,533	65.00
66.00	06600	PHYSICAL THERAPY	258,902	35,749	294,651	0	294,651	66.00
67.00	06700	OCCUPATIONAL THERAPY	96,958	7,907	104,865	0	104,865	67.00
68.00	06800	SPEECH PATHOLOGY	27,066	2,296	29,362	0	29,362	68.00
69.00	06900	ELECTROCARDIOLOGY	10,912	10,067	20,979	0	20,979	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	27,579	27,579	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	36,756	36,756	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	705,546	705,546	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	245	274,736	274,981	0	274,981	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,894,817	676,995	2,571,812	-78,256	2,493,556	88.00
91.00	09100	EMERGENCY	1,338,908	231,298	1,570,206	-37,621	1,532,585	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,021,599	21,190,009	29,211,608	-195,143	29,016,465	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	-15,798	-15,798	0	-15,798	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	62,286	62,286	194.01
194.02	07952	SENIOR CIRCLE	0	51	51	0	51	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	106,904	9,113	116,017	-278	115,739	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	133,135	133,135	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	8,128,503	21,183,375	29,311,878	0	29,311,878	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet A | Date/Time Prepared: 7/6/2023 3:25 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	39,459	283,589		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	373,685	957,132		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-23,397	1,026,327		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-10,945,370	4,468,909		5.00
7.00	00700	OPERATION OF PLANT	0	779,942		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	38,676		8.00
9.00	00900	HOUSEKEEPING	0	156,470		9.00
10.00	01000	DIETARY	239,586	504,661		10.00
11.00	01100	CAFETERIA	-60,523	229,740		11.00
13.00	01300	NURSING ADMINISTRATION	0	306,661		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	107,690		14.00
15.00	01500	PHARMACY	0	281,055		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-9	54,982		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-187,066	1,411,080		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	317,490		50.00
53.00	05300	ANESTHESIOLOGY	-190,091	3,932		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,681	827,587		54.00
60.00	06000	LABORATORY	-17,980	746,762		60.00
65.00	06500	RESPIRATORY THERAPY	0	218,533		65.00
66.00	06600	PHYSICAL THERAPY	0	294,651		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	104,865		67.00
68.00	06800	SPEECH PATHOLOGY	0	29,362		68.00
69.00	06900	ELECTROCARDIOLOGY	0	20,979		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	27,579		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	36,756		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	705,546		73.00
76.00	03610	BLANK	0	0		76.00
76.01	03550	SLEEP LAB	0	0		76.01
76.02	03020	PSYCH SERVICES	-23,693	251,288		76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-323,674	2,169,882		88.00
91.00	09100	EMERGENCY	-442,814	1,089,771		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,564,568	17,451,897		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-15,798		192.00
194.00	07950	HOME HEALTH	0	0		194.00
194.01	07951	MARKETING	0	62,286		194.01
194.02	07952	SENIOR CIRCLE	0	51		194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	115,739		194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0		194.04
194.05	07955	FREE STANDING NURSING HOME	0	133,135		194.05
194.06	07956	CLINIC CORPORATION	0	0		194.06
194.07	07957	VACANT SPACE	0	0		194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,564,568	17,747,310		200.00

RECLASSIFICATIONS | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet A-6 | Date/Time Prepared: 7/6/2023 3:25 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	941,063	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	45,075	2.00
3.00		0.00	0	0	3.00
	0		0	986,138	
	B - OXYGEN COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	7,121	1.00
2.00	EMERGENCY	91.00	0	278	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		0	7,399	
	D - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	68,268	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	10,746	2.00
	0		0	79,014	
	E - MARKETING COSTS				
1.00	MARKETING	194.01	36,411	25,875	1.00
	0		36,411	25,875	
	F - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	20,458	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	36,756	2.00
	0		0	57,214	
	G - RECLASS COST OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	705,546	1.00
	0		0	705,546	
	H - CAFETERIA COSTS				
1.00	CAFETERIA	11.00	0	290,263	1.00
	0		0	290,263	
	I - ALLOCATE NUSRSING HOME COSTS				
1.00	FREE STANDING NURSING HOME	194.05	129,634	3,501	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	0		129,634	3,501	
	J - RHC ATHENA COLLECTION FEES				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	123,331	1.00
	0		0	123,331	
500.00	Grand Total: Increases		166,045	2,278,281	500.00

RECLASSIFICATIONS | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet A-6 | Date/Time Prepared: 7/6/2023 3:25 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,060	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	946,179	0		2.00
3.00	EMERGENCY	91.00	0	37,899	0		3.00
	0		0	986,138			
	B - OXYGEN COSTS						
1.00	OPERATING ROOM	50.00	0	116	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	199	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	6,806	0		3.00
4.00	RED BUD SPECIALTY CLINIC	194.03	0	278	0		4.00
	0		0	7,399			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	79,014	12		1.00
2.00		0.00	0	0	13		2.00
	0		0	79,014			
	E - MARKETING COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	36,411	25,875	0		1.00
	0		36,411	25,875			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	56,819	0		1.00
2.00	OPERATING ROOM	50.00	0	395	0		2.00
	0		0	57,214			
	G - RECLASS COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	705,546	0		1.00
	0		0	705,546			
	H - CAFETERIA COSTS						
1.00	DIETARY	10.00	0	290,263	0		1.00
	0		0	290,263			
	I - ALLOCATE NUSRSING HOME COSTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	15,067	0	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	33,452	1,709	0		2.00
3.00	OPERATION OF PLANT	7.00	41,840	1,792	0		3.00
4.00	HOUSEKEEPING	9.00	9,746	0	0		4.00
5.00	NURSING ADMINISTRATION	13.00	29,529	0	0		5.00
	0		129,634	3,501			
	J - RHC ATHENA COLLECTION FEES						
1.00	RURAL HEALTH CLINIC	88.00	0	123,331	0		1.00
	0		0	123,331			
500.00	Grand Total: Decreases		166,045	2,278,281			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet A-7 Part I | Date/Time Prepared: 7/6/2023 3:25 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	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	0	0	0	0	0	1.00
2.00	Land Improvements	311,428	0	0	0	0	2.00
3.00	Buildings and Fixtures	4,596,573	0	0	0	0	3.00
4.00	Building Improvements	5,098,421	0	0	0	0	4.00
5.00	Fixed Equipment	2,512,786	0	0	0	0	5.00
6.00	Movable Equipment	17,091,022	0	0	0	0	6.00
7.00	HIT designated Assets	3,709,787	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,320,017	0	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	33,320,017	0	0	0	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	311,428	0	2.00
3.00	Buildings and Fixtures	4,596,573	0	3.00
4.00	Building Improvements	5,098,421	0	4.00
5.00	Fixed Equipment	2,512,786	0	5.00
6.00	Movable Equipment	17,091,022	0	6.00
7.00	HIT designated Assets	3,709,787	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,320,017	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	33,320,017	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet A-7 Part II | Date/Time Prepared: 7/6/2023 3:25 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	175,862	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	572,701	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	748,563	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	175,862		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	572,701		2.00
3.00	Total (sum of lines 1-2)	0	748,563		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet A-7 Part III Date/Time Prepared: 7/6/2023 3:25 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	12,519,208	0	12,519,208	0.375726	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	20,800,809	0	20,800,809	0.624274	0	2.00
3.00	Total (sum of lines 1-2)	33,320,017	0	33,320,017	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	131,208	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	804,045	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	935,253	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	84,113	68,268	0	0	283,589	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	142,341	0	10,746	0	957,132	2.00
3.00	Total (sum of lines 1-2)	226,454	68,268	10,746	0	1,240,721	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet A-8 | Date/Time Prepared: 7/6/2023 3:25 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,684	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-188	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-478,823			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	57,205			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-60,523	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	0	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-9	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-44,654	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	232,073	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
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	PATIENT TELEPHONE BENEFITS EXPENSE	A	-334	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
36.00	COST OF ER PROFESSIONAL BILLING	A	-2,792	EMERGENCY	91.00	0	36.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet A-8 | Date/Time Prepared: 7/6/2023 3:25 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
38.00	NON RHC COSTS	A	-323,674	RURAL HEALTH CLINIC	88.00	0	38.00
38.03	TELEPHONE SERVICES	A	-2,230	ADMINISTRATIVE & GENERAL	5.00	0	38.03
38.04	NH RADIOLOGY COSTS	A	-1,862	RADIOLOGY-DIAGNOSTIC	54.00	9	38.04
39.00	ADVERTISING	A	0	ADMINISTRATIVE & GENERAL	5.00	0	39.00
39.01	PROFESSIONAL FEE BENEFITS	A	509	ADULTS & PEDIATRICS	30.00	0	39.01
39.02	NH LAB COSTS	A	-5,331	LABORATORY	60.00	0	39.02
41.00	PROFESSIONAL FEE BENEFITS	A	-19,209	EMERGENCY	91.00	0	41.00
42.00	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-6,180	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	LOBBYING EXPENSE	A	-13,833	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY) (3)	A	0		0.00	0	45.00
45.01	CRNA COSTS	A	-190,091	ANESTHESIOLOGY	53.00	0	45.01
45.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.02
45.03	ILLINOIS PROVIDER TAX	A	-843,325	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	ADD BACK NH CREDIT FOR DIETARY	A	239,586	DIETARY	10.00	0	45.04
45.06	MISCELLANEOUS INCOME	B	0	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07	CHARITABLE CONTRIBUTIONS	A	-200	ADMINISTRATIVE & GENERAL	5.00	0	45.07
45.08	OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	45.08
45.09	PATIENT TV - CABLE EXPENSE	A	-12,743	ADULTS & PEDIATRICS	30.00	0	45.09
45.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.10
45.11	DEPRECIATION ADJ	A	-80,211	ADMINISTRATIVE & GENERAL	5.00	0	45.11
45.12	PATIENT PHONE DEPRECIATION	A	-541	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.12
45.13	MARKETING	A	-8,934	ADMINISTRATIVE & GENERAL	5.00	0	45.13
45.14	HOSPITALIST SALARY	A	-153,983	ADULTS & PEDIATRICS	30.00	0	45.14
45.15	HOSPITALIST BENEFITS	A	-23,063	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.15
45.16	LOSS ON SALE OF ENTITY	A	-9,817,524	ADMINISTRATIVE & GENERAL	5.00	0	45.16
45.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.17
45.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.18
45.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.19
45.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,564,568				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: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet A-8-1 | Date/Time Prepared: 7/6/2023 3:25 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00			0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	POOLED ALLOCATION OF NON-CAP	296,147	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	84,113	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	142,341	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL FUNCTIONAL ALLOC	367,453	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	141,401	304,574	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	669,676	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
4.06	0.00			0	0	4.06
4.07	0.00			0	0	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,031,455	974,250	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	QUORUM HEALTH C	100.00	QUORUM HEALTH C	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-1348	Period: From 07/01/2022 To 01/13/2023	Worksheet A-8-1 Date/Time Prepared: 7/6/2023 3:25 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	296,147	0		2.00
3.00	84,113	11		3.00
4.00	142,341	11		4.00
4.01	367,453	0		4.01
4.02	-163,173	0		4.02
4.03	-669,676	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
5.00	57,205			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	HOSPITAL CORP		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet A-8-2 | Date/Time Prepared: 7/6/2023 3:25 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	20,849	20,849	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	819	819	0	0	0	2.00
3.00	60.00	LABORATORY	12,649	12,649	0	0	0	3.00
4.00	91.00	EMERGENCY	852,857	420,813	432,044	0	0	4.00
5.00	76.02	PSYCH SERVICES	23,693	23,693	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			910,867	478,823	432,044		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	76.02	PSYCH SERVICES	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	20,849		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	819		2.00
3.00	60.00	LABORATORY	0	0	0	12,649		3.00
4.00	91.00	EMERGENCY	0	0	0	420,813		4.00
5.00	76.02	PSYCH SERVICES	0	0	0	23,693		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	478,823		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet B Part I | Date/Time Prepared: 7/6/2023 3:25 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	283,589	283,589				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	957,132		957,132			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,026,327	5,232	18,256	1,049,815		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,468,909	42,330	147,696	126,056	4,784,991	5.00
7.00	00700	OPERATION OF PLANT	779,942	64,731	225,862	12,311	1,082,846	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	38,676	625	2,182	0	41,483	8.00
9.00	00900	HOUSEKEEPING	156,470	4,516	15,758	15,843	192,587	9.00
10.00	01000	DIETARY	504,661	12,069	42,111	0	558,841	10.00
11.00	01100	CAFETERIA	229,740	7,111	24,811	0	261,662	11.00
13.00	01300	NURSING ADMINISTRATION	306,661	3,290	11,480	28,511	349,942	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	107,690	2,570	8,966	4,026	123,252	14.00
15.00	01500	PHARMACY	281,055	3,413	11,907	29,163	325,538	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	54,982	7,195	25,104	0	87,281	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,411,080	29,114	101,585	179,125	1,720,904	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	317,490	15,312	53,425	23,937	410,164	50.00
53.00	05300	ANESTHESIOLOGY	3,932	347	1,210	0	5,489	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	827,587	11,242	39,225	48,546	926,600	54.00
60.00	06000	LABORATORY	746,762	6,531	22,787	49,766	825,846	60.00
65.00	06500	RESPIRATORY THERAPY	218,533	816	2,846	23,507	245,702	65.00
66.00	06600	PHYSICAL THERAPY	294,651	10,005	34,908	33,785	373,349	66.00
67.00	06700	OCCUPATIONAL THERAPY	104,865	1,124	3,922	12,652	122,563	67.00
68.00	06800	SPEECH PATHOLOGY	29,362	0	0	3,532	32,894	68.00
69.00	06900	ELECTROCARDIOLOGY	20,979	567	1,977	1,424	24,947	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,579	0	0	0	27,579	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,756	0	0	0	36,756	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	705,546	0	0	0	705,546	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	251,288	4,951	17,276	32	273,547	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,169,882	23,592	82,316	247,264	2,523,054	88.00
91.00	09100	EMERGENCY	1,089,771	6,843	23,878	174,718	1,295,210	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,451,897	263,526	919,488	1,014,198	17,358,573	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	-15,798	8,448	0	0	-7,350	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	62,286	734	2,562	4,751	70,333	194.01
194.02	07952	SENIOR CIRCLE	51	1,468	5,124	0	6,643	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	115,739	8,586	29,958	13,950	168,233	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	133,135	0	0	16,916	150,051	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	827	0	0	827	194.07
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)	17,747,310	283,589	957,132	1,049,815	17,747,310	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet B Part I | Date/Time Prepared: 7/6/2023 3:25 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,784,991					5.00
7.00	00700	OPERATION OF PLANT	404,178	1,487,024				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,484	5,711	62,678			8.00
9.00	00900	HOUSEKEEPING	71,884	41,240	9,004	314,715		9.00
10.00	01000	DIETARY	208,590	110,207	1,130	22,974	901,742	10.00
11.00	01100	CAFETERIA	97,667	64,932	0	13,536	0	11.00
13.00	01300	NURSING ADMINISTRATION	130,618	30,045	0	6,263	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	46,004	23,465	0	4,892	0	14.00
15.00	01500	PHARMACY	121,509	31,162	0	6,496	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,578	65,698	0	13,696	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	642,336	265,854	21,346	55,424	193,466	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	153,096	139,817	6,913	29,147	0	50.00
53.00	05300	ANESTHESIOLOGY	2,049	3,166	0	660	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	345,858	102,654	7,236	21,400	0	54.00
60.00	06000	LABORATORY	308,251	59,635	48	12,432	0	60.00
65.00	06500	RESPIRATORY THERAPY	91,710	7,449	0	1,553	0	65.00
66.00	06600	PHYSICAL THERAPY	139,354	91,356	3,695	19,045	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	45,747	10,263	0	2,140	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,278	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	9,312	5,173	0	1,078	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,294	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,719	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	263,349	0	0	0	0	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	102,103	45,212	0	9,425	0	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	941,744	215,426	0	44,909	0	88.00
91.00	09100	EMERGENCY	483,444	62,490	13,192	13,027	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,693,156	1,380,955	62,564	278,097	193,466	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	16,081	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	26,252	6,704	0	1,398	0	194.01
194.02	07952	SENIOR CIRCLE	2,480	13,409	0	2,795	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	62,794	78,403	114	16,344	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	708,276	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	309	7,553	0	0	0	194.07
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)	4,784,991	1,487,024	62,678	314,715	901,742	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet B Part I | Date/Time Prepared: 7/6/2023 3:25 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	437,797					11.00
13.00	01300	NURSING ADMINISTRATION	13,979	530,847				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,304	4,903	206,820			14.00
15.00	01500	PHARMACY	9,958	35,515	2,328	532,506		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	199,253	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	105,546	218,142	21,637	0	20,983	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,209	29,151	10,968	0	16,643	50.00
53.00	05300	ANESTHESIOLOGY	0	0	719	0	476	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,334	0	5,732	0	46,639	54.00
60.00	06000	LABORATORY	36,470	0	72,512	0	42,160	60.00
65.00	06500	RESPIRATORY THERAPY	14,104	28,628	4,729	0	3,637	65.00
66.00	06600	PHYSICAL THERAPY	24,722	0	603	0	11,486	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,879	0	4	0	3,369	67.00
68.00	06800	SPEECH PATHOLOGY	1,508	0	53	0	653	68.00
69.00	06900	ELECTROCARDIOLOGY	31	1,734	0	0	4,508	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	23,460	0	3,593	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	12,891	0	878	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	532,506	11,905	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	31	0	11	0	737	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	118,018	0	39,753	0	8,637	88.00
91.00	09100	EMERGENCY	37,569	212,774	10,872	0	22,949	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	417,662	530,847	206,272	532,506	199,253	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	3,173	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	7,947	0	548	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	9,015	0	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
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)	437,797	530,847	206,820	532,506	199,253	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet B Part I | Date/Time Prepared: 7/6/2023 3:25 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,265,638	0	3,265,638		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	812,108	0	812,108		50.00
53.00	05300	ANESTHESIOLOGY	12,559	0	12,559		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,484,453	0	1,484,453		54.00
60.00	06000	LABORATORY	1,357,354	0	1,357,354		60.00
65.00	06500	RESPIRATORY THERAPY	397,512	0	397,512		65.00
66.00	06600	PHYSICAL THERAPY	663,610	0	663,610		66.00
67.00	06700	OCCUPATIONAL THERAPY	190,965	0	190,965		67.00
68.00	06800	SPEECH PATHOLOGY	47,386	0	47,386		68.00
69.00	06900	ELECTROCARDIOLOGY	46,783	0	46,783		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,926	0	64,926		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,244	0	64,244		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,513,306	0	1,513,306		73.00
76.00	03610	BLANK	0	0	0		76.00
76.01	03550	SLEEP LAB	0	0	0		76.01
76.02	03020	PSYCH SERVICES	431,066	0	431,066		76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	3,891,541	0	3,891,541		88.00
91.00	09100	EMERGENCY	2,151,527	0	2,151,527		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,394,978	0	16,394,978		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,731	0	8,731		192.00
194.00	07950	HOME HEALTH	0	0	0		194.00
194.01	07951	MARKETING	107,860	0	107,860		194.01
194.02	07952	SENIOR CIRCLE	25,327	0	25,327		194.02
194.03	07953	RED BUD SPECIALTY CLINIC	334,383	0	334,383		194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0		194.04
194.05	07955	FREE STANDING NURSING HOME	867,342	0	867,342		194.05
194.06	07956	CLINIC CORPORATION	0	0	0		194.06
194.07	07957	VACANT SPACE	8,689	0	8,689		194.07
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	17,747,310	0	17,747,310		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet B Part II | Date/Time Prepared: 7/6/2023 3:25 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,232	18,256	23,488	23,488	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	42,330	147,696	190,026	2,821	5.00
7.00	00700	OPERATION OF PLANT	0	64,731	225,862	290,593	275	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	625	2,182	2,807	0	8.00
9.00	00900	HOUSEKEEPING	0	4,516	15,758	20,274	355	9.00
10.00	01000	DIETARY	0	12,069	42,111	54,180	0	10.00
11.00	01100	CAFETERIA	0	7,111	24,811	31,922	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,290	11,480	14,770	638	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,570	8,966	11,536	90	14.00
15.00	01500	PHARMACY	0	3,413	11,907	15,320	653	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,195	25,104	32,299	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	29,114	101,585	130,699	4,008	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	15,312	53,425	68,737	536	50.00
53.00	05300	ANESTHESIOLOGY	0	347	1,210	1,557	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,242	39,225	50,467	1,086	54.00
60.00	06000	LABORATORY	0	6,531	22,787	29,318	1,114	60.00
65.00	06500	RESPIRATORY THERAPY	0	816	2,846	3,662	526	65.00
66.00	06600	PHYSICAL THERAPY	0	10,005	34,908	44,913	756	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,124	3,922	5,046	283	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	79	68.00
69.00	06900	ELECTROCARDIOLOGY	0	567	1,977	2,544	32	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	4,951	17,276	22,227	1	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	23,592	82,316	105,908	5,528	88.00
91.00	09100	EMERGENCY	0	6,843	23,878	30,721	3,910	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	263,526	919,488	1,183,014	22,691	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	8,448	0	8,448	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	734	2,562	3,296	106	194.01
194.02	07952	SENIOR CIRCLE	0	1,468	5,124	6,592	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	8,586	29,958	38,544	312	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	379	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	827	0	827	0	194.07
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	283,589	957,132	1,240,721	23,488	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet B Part II Date/Time Prepared: 7/6/2023 3:25 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	192,847					5.00
7.00	00700	OPERATION OF PLANT	16,289	307,157				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	624	1,180	4,611			8.00
9.00	00900	HOUSEKEEPING	2,897	8,518	662	32,706		9.00
10.00	01000	DIETARY	8,407	22,764	83	2,388	87,822	10.00
11.00	01100	CAFETERIA	3,936	13,412	0	1,407	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,264	6,206	0	651	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,854	4,847	0	508	0	14.00
15.00	01500	PHARMACY	4,897	6,437	0	675	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,313	13,570	0	1,423	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,888	54,914	1,570	5,760	18,842	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,170	28,880	509	3,029	0	50.00
53.00	05300	ANESTHESIOLOGY	83	654	0	69	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,939	21,204	532	2,224	0	54.00
60.00	06000	LABORATORY	12,423	12,318	4	1,292	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,696	1,539	0	161	0	65.00
66.00	06600	PHYSICAL THERAPY	5,616	18,870	272	1,979	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,844	2,120	0	222	0	67.00
68.00	06800	SPEECH PATHOLOGY	495	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	375	1,069	0	112	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	415	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	553	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,614	0	0	0	0	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	4,115	9,339	0	980	0	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	37,955	44,498	0	4,667	0	88.00
91.00	09100	EMERGENCY	19,484	12,908	971	1,354	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	189,146	285,247	4,603	28,901	18,842	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,671	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	1,058	1,385	0	145	0	194.01
194.02	07952	SENIOR CIRCLE	100	2,770	0	290	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	2,531	16,195	8	1,699	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	68,980	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	12	1,560	0	0	0	194.07
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)	192,847	307,157	4,611	32,706	87,822	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet B Part II | Date/Time Prepared: 7/6/2023 3:25 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	50,677					11.00
13.00	01300	NURSING ADMINISTRATION	1,618	29,147				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	498	269	19,602			14.00
15.00	01500	PHARMACY	1,153	1,950	221	31,306		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	48,605	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,217	11,977	2,051	0	5,120	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,876	1,601	1,040	0	4,061	50.00
53.00	05300	ANESTHESIOLOGY	0	0	68	0	116	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,280	0	543	0	11,368	54.00
60.00	06000	LABORATORY	4,222	0	6,873	0	10,287	60.00
65.00	06500	RESPIRATORY THERAPY	1,633	1,572	448	0	887	65.00
66.00	06600	PHYSICAL THERAPY	2,862	0	57	0	2,803	66.00
67.00	06700	OCCUPATIONAL THERAPY	796	0	0	0	822	67.00
68.00	06800	SPEECH PATHOLOGY	175	0	5	0	159	68.00
69.00	06900	ELECTROCARDIOLOGY	4	95	0	0	1,100	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,223	0	877	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,222	0	214	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	31,306	2,905	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	4	0	1	0	180	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,659	0	3,768	0	2,107	88.00
91.00	09100	EMERGENCY	4,349	11,683	1,030	0	5,599	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,346	29,147	19,550	31,306	48,605	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	367	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	920	0	52	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	1,044	0	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
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)	50,677	29,147	19,602	31,306	48,605	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet B Part II | Date/Time Prepared: 7/6/2023 3:25 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	273,046	0	273,046		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	116,439	0	116,439		50.00
53.00	05300	ANESTHESIOLOGY	2,547	0	2,547		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	104,643	0	104,643		54.00
60.00	06000	LABORATORY	77,851	0	77,851		60.00
65.00	06500	RESPIRATORY THERAPY	14,124	0	14,124		65.00
66.00	06600	PHYSICAL THERAPY	78,128	0	78,128		66.00
67.00	06700	OCCUPATIONAL THERAPY	11,133	0	11,133		67.00
68.00	06800	SPEECH PATHOLOGY	913	0	913		68.00
69.00	06900	ELECTROCARDIOLOGY	5,331	0	5,331		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,515	0	3,515		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,989	0	1,989		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,825	0	44,825		73.00
76.00	03610	BLANK	0	0	0		76.00
76.01	03550	SLEEP LAB	0	0	0		76.01
76.02	03020	PSYCH SERVICES	36,847	0	36,847		76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	218,090	0	218,090		88.00
91.00	09100	EMERGENCY	92,009	0	92,009		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,081,430	0	1,081,430		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,119	0	10,119		192.00
194.00	07950	HOME HEALTH	0	0	0		194.00
194.01	07951	MARKETING	6,357	0	6,357		194.01
194.02	07952	SENIOR CIRCLE	9,752	0	9,752		194.02
194.03	07953	RED BUD SPECIALTY CLINIC	60,261	0	60,261		194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0		194.04
194.05	07955	FREE STANDING NURSING HOME	70,403	0	70,403		194.05
194.06	07956	CLINIC CORPORATION	0	0	0		194.06
194.07	07957	VACANT SPACE	2,399	0	2,399		194.07
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,240,721	0	1,240,721		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet B-1 | Date/Time Prepared: 7/6/2023 3:25 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	125,147					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		121,054				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,309	2,309	8,044,990			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,680	18,680	966,000	-4,784,991	12,819,618	5.00
7.00	00700	OPERATION OF PLANT	28,566	28,566	94,346	0	1,082,846	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	276	276	0	0	41,483	8.00
9.00	00900	HOUSEKEEPING	1,993	1,993	121,409	0	192,587	9.00
10.00	01000	DIETARY	5,326	5,326	0	0	558,841	10.00
11.00	01100	CAFETERIA	3,138	3,138	0	0	261,662	11.00
13.00	01300	NURSING ADMINISTRATION	1,452	1,452	218,490	0	349,942	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,134	1,134	30,853	0	123,252	14.00
15.00	01500	PHARMACY	1,506	1,506	223,484	0	325,538	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,175	3,175	0	0	87,281	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,848	12,848	1,372,682	0	1,720,904	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,757	6,757	183,436	0	410,164	50.00
53.00	05300	ANESTHESIOLOGY	153	153	0	0	5,489	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,961	4,961	372,022	0	926,600	54.00
60.00	06000	LABORATORY	2,882	2,882	381,368	0	825,846	60.00
65.00	06500	RESPIRATORY THERAPY	360	360	180,143	0	245,702	65.00
66.00	06600	PHYSICAL THERAPY	4,415	4,415	258,902	0	373,349	66.00
67.00	06700	OCCUPATIONAL THERAPY	496	496	96,958	0	122,563	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	27,066	0	32,894	68.00
69.00	06900	ELECTROCARDIOLOGY	250	250	10,912	0	24,947	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	27,579	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	36,756	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	705,546	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	2,185	2,185	245	0	273,547	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,411	10,411	1,894,817	0	2,523,054	88.00
91.00	09100	EMERGENCY	3,020	3,020	1,338,908	0	1,295,210	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	116,293	116,293	7,772,041	-4,784,991	12,573,582	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	3,728	0	0	7,350	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	324	324	36,411	0	70,333	194.01
194.02	07952	SENIOR CIRCLE	648	648	0	0	6,643	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	3,789	3,789	106,904	0	168,233	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	129,634	-150,051	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	365	0	0	0	827	194.07
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)	283,589	957,132	1,049,815		4,784,991	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.266047	7.906653	0.130493		0.373255	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			23,488		192,847	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002920		0.015043	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: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet B-1 | Date/Time Prepared: 7/6/2023 3:25 pm

		Cost Center Description	OPERATION OF PLANT (SQ FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FULL TIME EQUIVALENT)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	71,864					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	276	173,541				8.00
9.00	00900	HOUSEKEEPING	1,993	24,930	72,958			9.00
10.00	01000	DIETARY	5,326	3,129	5,326	86,233		10.00
11.00	01100	CAFETERIA	3,138	0	3,138	0	13,937	11.00
13.00	01300	NURSING ADMINISTRATION	1,452	0	1,452	0	445	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,134	0	1,134	0	137	14.00
15.00	01500	PHARMACY	1,506	0	1,506	0	317	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,175	0	3,175	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,848	59,099	12,848	18,501	3,360	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,757	19,141	6,757	0	516	50.00
53.00	05300	ANESTHESIOLOGY	153	0	153	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,961	20,036	4,961	0	902	54.00
60.00	06000	LABORATORY	2,882	134	2,882	0	1,161	60.00
65.00	06500	RESPIRATORY THERAPY	360	0	360	0	449	65.00
66.00	06600	PHYSICAL THERAPY	4,415	10,230	4,415	0	787	66.00
67.00	06700	OCCUPATIONAL THERAPY	496	0	496	0	219	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	48	68.00
69.00	06900	ELECTROCARDIOLOGY	250	0	250	0	1	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	2,185	0	2,185	0	1	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,411	0	10,411	0	3,757	88.00
91.00	09100	EMERGENCY	3,020	36,527	3,020	0	1,196	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,738	173,226	64,469	18,501	13,296	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3,728	0	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	324	0	324	0	101	194.01
194.02	07952	SENIOR CIRCLE	648	0	648	0	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	3,789	315	3,789	0	253	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	67,732	287	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	365	0	0	0	0	194.07
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)	1,487,024	62,678	314,715	901,742	437,797	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.692196	0.361171	4.313646	10.457041	31.412571	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	307,157	4,611	32,706	87,822	50,677	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.274143	0.026570	0.448285	1.018427	3.636148	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: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet B-1 | Date/Time Prepared: 7/6/2023 3:25 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING SALARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	3,340,418					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	30,853	589,726				14.00
15.00	01500	PHARMACY	223,484	6,637	705,546			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	79,701,583		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,372,682	61,695	0	8,393,170		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	183,436	31,274	0	6,657,048		50.00
53.00	05300	ANESTHESIOLOGY	0	2,050	0	190,243		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,343	0	18,656,484		54.00
60.00	06000	LABORATORY	0	206,771	0	16,863,862		60.00
65.00	06500	RESPIRATORY THERAPY	180,143	13,484	0	1,454,877		65.00
66.00	06600	PHYSICAL THERAPY	0	1,718	0	4,594,476		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10	0	1,347,733		67.00
68.00	06800	SPEECH PATHOLOGY	0	150	0	261,082		68.00
69.00	06900	ELECTROCARDIOLOGY	10,912	0	0	1,803,156		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	66,894	0	1,437,352		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	36,756	0	351,120		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	705,546	4,762,008		73.00
76.00	03610	BLANK	0	0	0	0		76.00
76.01	03550	SLEEP LAB	0	0	0	0		76.01
76.02	03020	PSYCH SERVICES	0	32	0	294,656		76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	113,351	0	3,454,868		88.00
91.00	09100	EMERGENCY	1,338,908	30,999	0	9,179,448		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,340,418	588,164	705,546	79,701,583		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	HOME HEALTH	0	0	0	0		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0		194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	1,562	0	0		194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0		194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0		194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0		194.06
194.07	07957	VACANT SPACE	0	0	0	0		194.07
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)	530,847	206,820	532,506	199,253		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.158916	0.350705	0.754743	0.002500		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	29,147	19,602	31,306	48,605		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.008726	0.033239	0.044371	0.000610		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: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet C Part I Date/Time Prepared: 7/6/2023 3:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,265,638		3,265,638	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	812,108		812,108	0	0	50.00
53.00	05300	ANESTHESIOLOGY	12,559		12,559	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,484,453		1,484,453	0	0	54.00
60.00	06000	LABORATORY	1,357,354		1,357,354	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	397,512	0	397,512	0	0	65.00
66.00	06600	PHYSICAL THERAPY	663,610	0	663,610	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	190,965	0	190,965	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	47,386	0	47,386	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	46,783		46,783	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,926		64,926	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,244		64,244	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,513,306		1,513,306	0	0	73.00
76.00	03610	BLANK	0		0	0	0	76.00
76.01	03550	SLEEP LAB	0		0	0	0	76.01
76.02	03020	PSYCH SERVICES	431,066		431,066	0	0	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,891,541		3,891,541	0	0	88.00
91.00	09100	EMERGENCY	2,151,527		2,151,527	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	246,996		246,996		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	16,641,974	0	16,641,974	0	0	200.00
201.00		Less Observation Beds	246,996		246,996		0	201.00
202.00		Total (see instructions)	16,394,978	0	16,394,978	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet C Part I Date/Time Prepared: 7/6/2023 3:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,585,896		7,585,896			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	616,186	6,040,862	6,657,048	0.121992	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	20,492	169,751	190,243	0.066016	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,692,236	16,964,248	18,656,484	0.079568	0.000000	54.00
60.00	06000	LABORATORY	4,063,915	12,799,947	16,863,862	0.080489	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	997,621	457,256	1,454,877	0.273227	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,003,336	2,591,140	4,594,476	0.144436	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,223,050	124,683	1,347,733	0.141693	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	161,153	99,929	261,082	0.181499	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	176,562	1,626,594	1,803,156	0.025945	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	941,024	496,328	1,437,352	0.045171	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,730	347,390	351,120	0.182969	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,521,867	3,240,141	4,762,008	0.317787	0.000000	73.00
76.00	03610	BLANK	0	0	0	0.000000	0.000000	76.00
76.01	03550	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	294,656	294,656	1.462947	0.000000	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,454,868	3,454,868			88.00
91.00	09100	EMERGENCY	541,966	8,637,482	9,179,448	0.234385	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	81,367	725,907	807,274	0.305963	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	21,630,401	58,071,182	79,701,583			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	21,630,401	58,071,182	79,701,583			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet C Part I Date/Time Prepared: 7/6/2023 3:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03610	BLANK	0.000000	76.00
76.01	03550	SLEEP LAB	0.000000	76.01
76.02	03020	PSYCH SERVICES	0.000000	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet C Part I Date/Time Prepared: 7/6/2023 3:25 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,265,638		3,265,638	0	3,265,638	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	812,108		812,108	0	812,108	50.00
53.00	05300	ANESTHESIOLOGY	12,559		12,559	0	12,559	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,484,453		1,484,453	0	1,484,453	54.00
60.00	06000	LABORATORY	1,357,354		1,357,354	0	1,357,354	60.00
65.00	06500	RESPIRATORY THERAPY	397,512	0	397,512	0	397,512	65.00
66.00	06600	PHYSICAL THERAPY	663,610	0	663,610	0	663,610	66.00
67.00	06700	OCCUPATIONAL THERAPY	190,965	0	190,965	0	190,965	67.00
68.00	06800	SPEECH PATHOLOGY	47,386	0	47,386	0	47,386	68.00
69.00	06900	ELECTROCARDIOLOGY	46,783		46,783	0	46,783	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,926		64,926	0	64,926	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,244		64,244	0	64,244	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,513,306		1,513,306	0	1,513,306	73.00
76.00	03610	BLANK	0		0	0	0	76.00
76.01	03550	SLEEP LAB	0		0	0	0	76.01
76.02	03020	PSYCH SERVICES	431,066		431,066	0	431,066	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,891,541		3,891,541	0	3,891,541	88.00
91.00	09100	EMERGENCY	2,151,527		2,151,527	0	2,151,527	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	246,996		246,996		246,996	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	16,641,974	0	16,641,974	0	16,641,974	200.00
201.00		Less Observation Beds	246,996		246,996		246,996	201.00
202.00		Total (see instructions)	16,394,978	0	16,394,978	0	16,394,978	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet C Part I Date/Time Prepared: 7/6/2023 3:25 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,585,896		7,585,896			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	616,186	6,040,862	6,657,048	0.121992	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	20,492	169,751	190,243	0.066016	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,692,236	16,964,248	18,656,484	0.079568	0.000000	54.00
60.00	06000	LABORATORY	4,063,915	12,799,947	16,863,862	0.080489	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	997,621	457,256	1,454,877	0.273227	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,003,336	2,591,140	4,594,476	0.144436	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,223,050	124,683	1,347,733	0.141693	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	161,153	99,929	261,082	0.181499	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	176,562	1,626,594	1,803,156	0.025945	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	941,024	496,328	1,437,352	0.045171	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,730	347,390	351,120	0.182969	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,521,867	3,240,141	4,762,008	0.317787	0.000000	73.00
76.00	03610	BLANK	0	0	0	0.000000	0.000000	76.00
76.01	03550	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	294,656	294,656	1.462947	0.000000	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,454,868	3,454,868	1.126394	0.000000	88.00
91.00	09100	EMERGENCY	541,966	8,637,482	9,179,448	0.234385	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	81,367	725,907	807,274	0.305963	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	21,630,401	58,071,182	79,701,583			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	21,630,401	58,071,182	79,701,583			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet C Part I Date/Time Prepared: 7/6/2023 3:25 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.121992		50.00
53.00	05300	ANESTHESIOLOGY	0.066016		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.079568		54.00
60.00	06000	LABORATORY	0.080489		60.00
65.00	06500	RESPIRATORY THERAPY	0.273227		65.00
66.00	06600	PHYSICAL THERAPY	0.144436		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.141693		67.00
68.00	06800	SPEECH PATHOLOGY	0.181499		68.00
69.00	06900	ELECTROCARDIOLOGY	0.025945		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.045171		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.182969		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317787		73.00
76.00	03610	BLANK	0.000000		76.00
76.01	03550	SLEEP LAB	0.000000		76.01
76.02	03020	PSYCH SERVICES	1.462947		76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	1.126394		88.00
91.00	09100	EMERGENCY	0.234385		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.305963		92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet C Part II Date/Time Prepared: 7/6/2023 3:25 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	812,108	116,439	695,669	0	0	50.00
53.00	05300	ANESTHESIOLOGY	12,559	2,547	10,012	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,484,453	104,643	1,379,810	0	0	54.00
60.00	06000	LABORATORY	1,357,354	77,851	1,279,503	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	397,512	14,124	383,388	0	0	65.00
66.00	06600	PHYSICAL THERAPY	663,610	78,128	585,482	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	190,965	11,133	179,832	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	47,386	913	46,473	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	46,783	5,331	41,452	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,926	3,515	61,411	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,244	1,989	62,255	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,513,306	44,825	1,468,481	0	0	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	431,066	36,847	394,219	0	0	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,891,541	218,090	3,673,451	0	0	88.00
91.00	09100	EMERGENCY	2,151,527	92,009	2,059,518	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	246,996	20,652	226,344	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
200.00		Subtotal (sum of lines 50 thru 199)	13,376,336	829,036	12,547,300	0	0	200.00
201.00		Less Observation Beds	246,996	20,652	226,344	0	0	201.00
202.00		Total (line 200 minus line 201)	13,129,340	808,384	12,320,956	0	0	202.00

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

Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet C Part II | Date/Time Prepared: 7/6/2023 3:25 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	812,108	6,657,048	0.121992		50.00
53.00	05300	ANESTHESIOLOGY	12,559	190,243	0.066016		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,484,453	18,656,484	0.079568		54.00
60.00	06000	LABORATORY	1,357,354	16,863,862	0.080489		60.00
65.00	06500	RESPIRATORY THERAPY	397,512	1,454,877	0.273227		65.00
66.00	06600	PHYSICAL THERAPY	663,610	4,594,476	0.144436		66.00
67.00	06700	OCCUPATIONAL THERAPY	190,965	1,347,733	0.141693		67.00
68.00	06800	SPEECH PATHOLOGY	47,386	261,082	0.181499		68.00
69.00	06900	ELECTROCARDIOLOGY	46,783	1,803,156	0.025945		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,926	1,437,352	0.045171		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,244	351,120	0.182969		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,513,306	4,762,008	0.317787		73.00
76.00	03610	BLANK	0	0	0.000000		76.00
76.01	03550	SLEEP LAB	0	0	0.000000		76.01
76.02	03020	PSYCH SERVICES	431,066	294,656	1.462947		76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	3,891,541	3,454,868	1.126394		88.00
91.00	09100	EMERGENCY	2,151,527	9,179,448	0.234385		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	246,996	807,274	0.305963		92.00
		OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0.000000		102.00
200.00		Subtotal (sum of lines 50 thru 199)	13,376,336	72,115,687			200.00
201.00		Less Observation Beds	246,996	0			201.00
202.00		Total (line 200 minus line 201)	13,129,340	72,115,687			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet D Part II Date/Time Prepared: 7/6/2023 3:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	116,439	6,657,048	0.017491	108,820	1,903	50.00
53.00	05300	ANESTHESIOLOGY	2,547	190,243	0.013388	3,614	48	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	104,643	18,656,484	0.005609	648,042	3,635	54.00
60.00	06000	LABORATORY	77,851	16,863,862	0.004616	1,519,831	7,016	60.00
65.00	06500	RESPIRATORY THERAPY	14,124	1,454,877	0.009708	413,520	4,014	65.00
66.00	06600	PHYSICAL THERAPY	78,128	4,594,476	0.017005	329,523	5,604	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,133	1,347,733	0.008261	112,718	931	67.00
68.00	06800	SPEECH PATHOLOGY	913	261,082	0.003497	27,298	95	68.00
69.00	06900	ELECTROCARDIOLOGY	5,331	1,803,156	0.002956	70,928	210	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,515	1,437,352	0.002445	388,581	950	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,989	351,120	0.005665	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,825	4,762,008	0.009413	487,223	4,586	73.00
76.00	03610	BLANK	0	0	0.000000	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03020	PSYCH SERVICES	36,847	294,656	0.125051	0	0	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	218,090	3,454,868	0.063125	0	0	88.00
91.00	09100	EMERGENCY	92,009	9,179,448	0.010023	112,275	1,125	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	20,652	807,274	0.025582	11,615	297	92.00
200.00		Total (lines 50 through 199)	829,036	72,115,687		4,233,988	30,414	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet D Part IV | Date/Time Prepared: 7/6/2023 3:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	0	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet D Part IV Date/Time Prepared: 7/6/2023 3:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	6,657,048	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	190,243	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	18,656,484	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	16,863,862	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,454,877	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,594,476	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,347,733	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	261,082	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,803,156	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,437,352	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	351,120	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,762,008	0.000000	73.00
76.00	03610	BLANK	0	0	0	0	0.000000	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	0	0	294,656	0.000000	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,454,868	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	9,179,448	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	807,274	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	72,115,687		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet D Part IV | Date/Time Prepared: 7/6/2023 3:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	108,820	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	3,614	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	648,042	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,519,831	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	413,520	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	329,523	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	112,718	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	27,298	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	70,928	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	388,581	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	487,223	0	0	0	73.00
76.00	03610	BLANK	0.000000	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0.000000	0	0	0	0	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	112,275	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	11,615	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,233,988	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet D Part V Date/Time Prepared: 7/6/2023 3:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.121992	0	1,315,935	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.066016	0	34,791	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.079568	0	5,093,023	0	0	54.00
60.00	06000	LABORATORY	0.080489	0	4,236,592	4,554	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.273227	0	141,148	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.144436	0	752,747	3,983	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.141693	0	17,040	2,446	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.181499	0	14,851	569	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.025945	0	540,855	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.045171	0	119,032	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.182969	0	126,619	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317787	0	2,210,640	747	0	73.00
76.00	03610	BLANK	0.000000	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	1.462947	0	286,836	0	0	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	0.234385	0	1,742,173	446	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.305963	0	319,913	0	0	92.00
200.00		Subtotal (see instructions)		0	16,952,195	12,745	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	16,952,195	12,745	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet D Part V Date/Time Prepared: 7/6/2023 3:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	160,534	0		50.00
53.00	05300	ANESTHESIOLOGY	2,297	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	405,242	0		54.00
60.00	06000	LABORATORY	340,999	367		60.00
65.00	06500	RESPIRATORY THERAPY	38,565	0		65.00
66.00	06600	PHYSICAL THERAPY	108,724	575		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,414	347		67.00
68.00	06800	SPEECH PATHOLOGY	2,695	103		68.00
69.00	06900	ELECTROCARDIOLOGY	14,032	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,377	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,167	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	702,513	237		73.00
76.00	03610	BLANK	0	0		76.00
76.01	03550	SLEEP LAB	0	0		76.01
76.02	03020	PSYCH SERVICES	419,626	0		76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	408,339	105		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	97,882	0		92.00
200.00		Subtotal (see instructions)	2,732,406	1,734		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,732,406	1,734		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet D Part I Date/Time Prepared: 7/6/2023 3:25 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	273,046	133,449	139,597	1,567	89.09	30.00
200.00	Total (lines 30 through 199)	273,046		139,597	1,567		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	10	891	30.00
200.00	Total (lines 30 through 199)	10	891	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet D Part II Date/Time Prepared: 7/6/2023 3:25 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	116,439	6,657,048	0.017491	0	0	50.00
53.00	05300	ANESTHESIOLOGY	2,547	190,243	0.013388	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	104,643	18,656,484	0.005609	0	0	54.00
60.00	06000	LABORATORY	77,851	16,863,862	0.004616	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	14,124	1,454,877	0.009708	0	0	65.00
66.00	06600	PHYSICAL THERAPY	78,128	4,594,476	0.017005	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,133	1,347,733	0.008261	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	913	261,082	0.003497	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,331	1,803,156	0.002956	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,515	1,437,352	0.002445	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,989	351,120	0.005665	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,825	4,762,008	0.009413	0	0	73.00
76.00	03610	BLANK	0	0	0.000000	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03020	PSYCH SERVICES	36,847	294,656	0.125051	0	0	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	218,090	3,454,868	0.063125	0	0	88.00
91.00	09100	EMERGENCY	92,009	9,179,448	0.010023	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	20,652	807,274	0.025582	0	0	92.00
200.00		Total (lines 50 through 199)	829,036	72,115,687		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet D Part III Date/Time Prepared: 7/6/2023 3:25 pm

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,567	0.00	10	30.00
200.00		Total (lines 30 through 199)		0	1,567		10	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet D Part IV Date/Time Prepared: 7/6/2023 3:25 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	0	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet D Part IV Date/Time Prepared: 7/6/2023 3:25 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	6,657,048	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	190,243	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	18,656,484	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	16,863,862	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,454,877	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,594,476	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,347,733	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	261,082	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,803,156	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,437,352	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	351,120	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,762,008	0.000000	73.00
76.00	03610	BLANK	0	0	0	0	0.000000	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	0	0	294,656	0.000000	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,454,868	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	9,179,448	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	807,274	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	72,115,687		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet D Part IV | Date/Time Prepared: 7/6/2023 3:25 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.00	03610	BLANK	0.000000	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0.000000	0	0	0	0	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet D-1 | Date/Time Prepared: 7/6/2023 3:25 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,081	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,567	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)	1,335	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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)	1,498	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	16	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	687	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	1,121	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	157.19	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,265,638	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	2,515	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,597,346	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,668,292	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,668,292	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,064.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	731,408	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)	731,408	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet D-1 | Date/Time Prepared: 7/6/2023 3:25 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	573,009	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,304,417	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,193,461	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	1,193,461	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)	232	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,064.64	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	246,996	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet D-1 | Date/Time Prepared: 7/6/2023 3:25 pm

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	273,046	3,265,638	0.083612	246,996	20,652	90.00
91.00	Nursing Program cost	0	3,265,638	0.000000	246,996	0	91.00
92.00	Allied health cost	0	3,265,638	0.000000	246,996	0	92.00
93.00	All other Medical Education	0	3,265,638	0.000000	246,996	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet D-1 | Date/Time Prepared: 7/6/2023 3:25 pm

Title XIX | Hospital | PPS

	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS			
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,081	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,567	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.	do	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,335	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	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)		1,498	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		16	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		10	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
	SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,265,638	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)	5	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)	x	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)	x	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	x	0	25.00
26.00	Total swing-bed cost (see instructions)		1,596,059	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,669,579	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 minus line 36)	27	1,669,579	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,065.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		10,655	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)		10,655	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet D-1 | Date/Time Prepared: 7/6/2023 3:25 pm

Title XIX | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	10,655	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)	891	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)	891	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	9,764	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	232	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,065.46	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	247,187	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet D-1 | Date/Time Prepared: 7/6/2023 3:25 pm

Title XIX | Hospital | PPS

	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	273,046	3,265,638	0.083612	247,187	20,668	90.00
91.00	Nursing Program cost	0	3,265,638	0.000000	247,187	0	91.00
92.00	Allied health cost	0	3,265,638	0.000000	247,187	0	92.00
93.00	All other Medical Education	0	3,265,638	0.000000	247,187	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet D-3 | Date/Time Prepared: 7/6/2023 3:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,612,159		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.121992	108,820	13,275	50.00
53.00	05300	ANESTHESIOLOGY	0.066016	3,614	239	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.079568	648,042	51,563	54.00
60.00	06000	LABORATORY	0.080489	1,519,831	122,330	60.00
65.00	06500	RESPIRATORY THERAPY	0.273227	413,520	112,985	65.00
66.00	06600	PHYSICAL THERAPY	0.144436	329,523	47,595	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.141693	112,718	15,971	67.00
68.00	06800	SPEECH PATHOLOGY	0.181499	27,298	4,955	68.00
69.00	06900	ELECTROCARDIOLOGY	0.025945	70,928	1,840	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.045171	388,581	17,553	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.182969	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317787	487,223	154,833	73.00
76.00	03610	BLANK	0.000000	0	0	76.00
76.01	03550	SLEEP LAB	0.000000	0	0	76.01
76.02	03020	PSYCH SERVICES	1.462947	0	0	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.234385	112,275	26,316	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.305963	11,615	3,554	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,233,988	573,009	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)		4,233,988		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet D-3

Component CCN: 14-Z348 | Date/Time Prepared: 7/6/2023 3:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.121992	2,939	359	50.00
53.00	05300	ANESTHESIOLOGY	0.066016	391	26	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.079568	56,716	4,513	54.00
60.00	06000	LABORATORY	0.080489	551,083	44,356	60.00
65.00	06500	RESPIRATORY THERAPY	0.273227	208,448	56,954	65.00
66.00	06600	PHYSICAL THERAPY	0.144436	1,041,489	150,429	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.141693	711,957	100,879	67.00
68.00	06800	SPEECH PATHOLOGY	0.181499	97,896	17,768	68.00
69.00	06900	ELECTROCARDIOLOGY	0.025945	17,305	449	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.045171	268,555	12,131	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.182969	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317787	315,606	100,295	73.00
76.00	03610	BLANK	0.000000	0	0	76.00
76.01	03550	SLEEP LAB	0.000000	0	0	76.01
76.02	03020	PSYCH SERVICES	1.462947	0	0	76.02
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.234385	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.305963	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,272,385	488,159	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)		3,272,385		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet E Part B Date/Time Prepared: 7/6/2023 3:25 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,734,140	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)	2,734,140	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)	2,761,481	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)	13,746	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,481,735	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)	266,000	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)	266,000	30.00
31.00	Primary payer payments	209	31.00
32.00	Subtotal (line 30 minus line 31)	265,791	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)	246,309	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	160,101	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	183,945	36.00
37.00	Subtotal (see instructions)	425,892	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)	425,892	40.00
40.01	Sequestration adjustment (see instructions)	8,518	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		40.03
41.00	Interim payments	879,106	41.00
41.01	Interim payments-PARHM or CHART		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-461,732	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: 14-1348	Period: From 07/01/2022 To 01/13/2023	Worksheet E Part B Date/Time Prepared: 7/6/2023 3:25 pm
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet E-1 Part I Date/Time Prepared: 7/6/2023 3:25 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		879,244		879,106	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	02/24/2023	89,000		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		89,000		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)		968,244		879,106	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		98,571		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		461,732	6.02
7.00	Total Medicare program liability (see instructions)		1,066,815		417,374	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: 14-1348 | Component CCN: 14-Z348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet E-1 Part I | Date/Time Prepared: 7/6/2023 3:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,418,869		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/24/2023	153,000		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		153,000		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)		1,571,869		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		71,229		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,643,098		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1348	Period: From 07/01/2022 To 01/13/2023	Worksheet E-1 Part II Date/Time Prepared: 7/6/2023 3:25 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1348 | Component CCN: 14-Z348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet E-2 | Date/Time Prepared: 7/6/2023 3:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,205,396	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)	493,041	0	3.00
3.01	Nursing and allied health payment-PARHM or CHART (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	1,121	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)	1,698,437	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,698,437	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,698,437	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	21,806	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,676,631	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,676,631	0	19.00
19.01	Sequestration adjustment (see instructions)	33,533	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM or CHART pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	1,571,869	0	20.00
20.01	Interim payments-PARHM or CHART			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM or CHART (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)	71,229	0	22.00
22.01	Balance due provider/program-PARHM or CHART (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: 14-1348	Period: From 07/01/2022 To 01/13/2023	Worksheet E-3 Part V Date/Time Prepared: 7/6/2023 3:25 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,304,417	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	1,304,417	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,317,461	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,317,461	19.00
20.00	Deductibles (exclude professional component)	232,108	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,085,353	22.00
23.00	Coinsurance	7,002	23.00
24.00	Subtotal (line 22 minus line 23)	1,078,351	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	15,747	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	10,236	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	7,521	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,088,587	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,088,587	30.00
30.01	Sequestration adjustment (see instructions)	21,772	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM or CHART		30.03
31.00	Interim payments	968,244	31.00
31.01	Interim payments-PARHM or CHART		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM or CHART (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	98,571	33.00
33.01	Balance due provider/program-PARHM or CHART (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: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet G | Date/Time Prepared: 7/6/2023 3:25 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-366,101	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,352,922	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,336,470	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	113,445	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)	-236,204	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	0	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	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	555,021	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	555,021	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	318,817	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,609,602	0	0	0	37.00
38.00	Salaries, wages, and fees payable	255,423	0	0	0	38.00
39.00	Payroll taxes payable	-1,802	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	7,262,249	0	0	0	43.00
44.00	Other current liabilities	-388,391	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,737,081	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	9,737,081	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-9,418,264				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)	-9,418,264	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	318,817	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet G-1 | Date/Time Prepared: 7/6/2023 3:25 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		155,442		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-9,573,709				2.00
3.00	Total (sum of line 1 and line 2)		-9,418,267		0		3.00
4.00	ROUNDING	3		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)		3		0		10.00
11.00	Subtotal (line 3 plus line 10)		-9,418,264		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-9,418,264		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	ROUNDING		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 7/6/2023 3:25 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,585,896		7,585,896	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,585,896		7,585,896	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)	7,585,896		7,585,896	17.00
18.00	Ancillary services	13,421,172	45,252,925	58,674,097	18.00
19.00	Outpatient services	623,333	9,363,389	9,986,722	19.00
20.00	RURAL HEALTH CLINIC	0	3,454,868	3,454,868	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 CHARGES	206,445	3,766,853	3,973,298	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	21,836,846	61,838,035	83,674,881	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		29,311,878		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)		29,311,878		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1348	Period: From 07/01/2022 To 01/13/2023	Worksheet G-3 Date/Time Prepared: 7/6/2023 3:25 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	83,674,881	1.00
2.00	Less contractual allowances and discounts on patients' accounts	64,186,644	2.00
3.00	Net patient revenues (line 1 minus line 2)	19,488,237	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	29,311,878	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-9,823,641	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	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	60,523	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	9	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	17,967	22.00
23.00	Governmental appropriations	168,918	23.00
24.00	OTHER INCOME	3,384	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	250,801	25.00
26.00	Total (line 5 plus line 25)	-9,572,840	26.00
27.00	GAIN/LOSS SALE OF DISP F/A	869	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	869	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-9,573,709	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1348 | Component CCN: 14-8514 | Period: From 07/01/2022 To 01/13/2023 | Worksheet M-1 | Date/Time Prepared: 7/6/2023 3:25 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	805,556	0	805,556	0	805,556	1.00
2.00	Physician Assistant	128,847	0	128,847	0	128,847	2.00
3.00	Nurse Practitioner	455,528	0	455,528	0	455,528	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	310,828	0	310,828	0	310,828	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	22,899	0	22,899	0	22,899	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	119,788	119,992	239,780	45,075	284,855	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,843,446	119,992	1,963,438	45,075	2,008,513	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	197,731	197,731	0	197,731	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	1,222	1,222	0	1,222	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	198,953	198,953	0	198,953	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,843,446	318,945	2,162,391	45,075	2,207,466	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	2,534	0	2,534	0	2,534	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	2,534	0	2,534	0	2,534	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	30,158	30,158	0	30,158	29.00
30.00	Administrative Costs	48,837	327,892	376,729	-123,331	253,398	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	48,837	358,050	406,887	-123,331	283,556	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,894,817	676,995	2,571,812	-78,256	2,493,556	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1348 | Component CCN: 14-8514 | Period: From 07/01/2022 To 01/13/2023 | Worksheet M-1 | Date/Time Prepared: 7/6/2023 3:25 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-261,793	543,763		1.00
2.00	Physician Assistant	-3,751	125,096		2.00
3.00	Nurse Practitioner	-24,545	430,983		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	310,828		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	22,899		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	-33,585	251,270		9.00
10.00	Subtotal (sum of lines 1 through 9)	-323,674	1,684,839		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	197,731		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	1,222		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	198,953		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-323,674	1,883,792		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	2,534		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	2,534		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	30,158		29.00
30.00	Administrative Costs	0	253,398		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	283,556		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-323,674	2,169,882		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1348 | Component CCN: 14-8514 | Period: From 07/01/2022 To 01/13/2023 | Worksheet M-2 | Date/Time Prepared: 7/6/2023 3:25 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.00	2,271	2,423	2,423		1.00
2.00	Physician Assistant	1.30	1,508	1,212	1,576		2.00
3.00	Nurse Practitioner	4.62	5,777	1,212	5,599		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.92	9,556		9,598	9,598	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	0.39	168			168	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)	7.31	9,724			9,766	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,883,792	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					2,534	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,886,326	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.998657	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					283,556	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,721,659	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,005,215	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,005,215	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,002,522	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,886,314	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1348 Component CCN: 14-8514	Period: From 07/01/2022 To 01/13/2023	Worksheet M-3 Date/Time Prepared: 7/6/2023 3:25 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,886,314	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			3,886,314	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			9,766	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)			9,766	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			397.94	7.00
		Calculation of Limit (1)			
		Rate Period 1 (07/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 01/13/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	372.78	386.95		8.00
9.00	Rate for Program covered visits (see instructions)	372.78	386.95		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	2,678	175		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	998,305	67,716		11.00
12.00	Program covered visits for mental health services (from contractor records)	42	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	15,657	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	15,657	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,081,678		16.00
16.01	Total program charges (see instructions)(from contractor's records)		635,001		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		67,760		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		115,424		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.)		748,820		16.04
16.05	Total program cost (see instructions)	0	864,244		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		30,229		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		107,402		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		864,244		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		864,244		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)		864,244		26.00
26.01	Sequestration adjustment (see instructions)		17,285		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		845,176		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)		1,783		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: 14-1348 | Period: From 07/01/2022 To 01/13/2023 | Worksheet M-4

Component CCN: 14-8514 | Date/Time Prepared: 7/6/2023 3:25 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,684,839	1,684,839	1,684,839	1,684,839	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000000	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	0	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	0	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	0	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,883,792	1,883,792	1,883,792	1,883,792	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,002,522	2,002,522	2,002,522	2,002,522	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.000000	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	0	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	0	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	0	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	0.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	0	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	0	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)		0	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)		0	16.00

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

Provider CCN: 14-1348 | Component CCN: 14-8514 | Period: From 07/01/2022 To 01/13/2023 | Worksheet M-5 | Date/Time Prepared: 7/6/2023 3:25 pm

RHC I | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		845,176	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		845,176	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		1,783	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		846,959	7.00

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