

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: 14-1310	Period: From 10/01/2022 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/25/2024 7:10 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 2/25/2024	Time: 7:10 pm
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 MENDOTA COMMUNITY HOSPITAL (14-1310) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-49,435	-1,263,376	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	-30,018	0	0	5.00
6.00	SWING BED - NF	0			0	6.00
10.00	RURAL HEALTH CLINIC I	0		169,381	0	10.00
200.00	TOTAL	0	-79,453	-1,093,995	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: 14-1310		Period: From 10/01/2022 To 09/30/2023		Worksheet S-2 Part I Date/Time Prepared: 2/25/2024 7:10 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1401 EAST 12TH ST			PO Box:				1.00		
2.00	City: MENDOTA			State: IL		Zip Code: 61342-9216		County: LA SALLE 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		MENDOTA COMMUNITY HOSPITAL	141310	99914	1	01/15/2001	N	O	N
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF		MENDOTA COMMUNITY SWING BED- SNF	14Z310	99914		01/25/2001	N	O	N
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		MENDOTA COMMUNITY HOSPITAL - RHC	148535	99914		02/11/2015	N	O	N
16.00	Hospital-Based Health Clinic - FOHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2022	09/30/2023		20.00	
21.00	Type of Control (see instructions)					1			21.00	
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				N	N			22.00	
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	N			22.01	
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	N	N		22.03	
22.04	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	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)								23.00	
23.00	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.								23.00	
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: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet S-2
Part I
Date/Time Prepared:
2/25/2024 7:10 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	0	25.00
					Urban/Rural	S	Date of Geogr
					1.00		2.00
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						2	26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						2	27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0	35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						0	37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)						N	N
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
					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
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
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
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						N	N
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	
57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.						N	

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		V	XVIII	XIX			
		1.00	2.00	3.00			
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N					59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.20
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during 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

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Period:
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Date/Time Prepared:
2/25/2024 7:10 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

Health Financial Systems		MENDOTA COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1310	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part I Date/Time Prepared: 2/25/2024 7:10 pm	
			1.00		
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?			68.00	
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
			1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.			N	0 88.00
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge
			1.00	2.00	3.00
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.			0.00	0 89.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y 90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N 91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N 92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N 93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N 94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00 95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N 96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00 97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1310		Period: From 10/01/2022 To 09/30/2023		Worksheet S-2 Part I Date/Time Prepared: 2/25/2024 7:10 pm	
				V	XIX		
				1.00	2.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N			98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y			98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y			98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N			98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N			98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y			98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N			98.06	
Rural Providers							
105.00	Does this hospital qualify as a CAH?	Y				105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y				106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00	
					1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
					1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
					1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				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	

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		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	11,979	0	17,455
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	Y	123.00
Certified Transplant Center Information				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB1728	140.00
		1.00	2.00	3.00
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name: OSF HEALTHCARE SYSTEM	Contractor's Name: WPS		Contractor's Number: 05901
142.00	Street: 124 SW ADAMS	PO Box:		
143.00	City: PEORIA	State: IL		Zip Code: 61602
		1.00	2.00	
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: 14-1310		Period: From 10/01/2022 To 09/30/2023		Worksheet S-2 Part I Date/Time Prepared: 2/25/2024 7:10 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	
						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	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1310		Period: From 10/01/2022 To 09/30/2023		Worksheet S-2 Part II Date/Time Prepared: 2/25/2024 7:10 pm	
				Y/N	Date		
				1.00	2.00		
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			Y			13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/13/2023	Y	12/13/2023		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet S-2
Part II
Date/Time Prepared:
2/25/2024 7:10 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		Y		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		Y		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA		RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	FORVIS			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544		PATTY. RACHELL@FORVIS.COM	43.00

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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGING DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet S-3
Part I
Date/Time Prepared:
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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	21	7,665	35,151.12	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)		21	7,665	35,151.12	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	742.17	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	35,893.29	0	14.00
15.00 CAH visits					0	15.00
15.10 REH hours and visits						15.10
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01
34.00 Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

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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)	753	28	1,465		1.00
2.00	HMO and other (see instructions)	362	80			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	602	0	889		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	173		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,355	28	2,527		7.00
8.00	INTENSIVE CARE UNIT	25	13	62		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)	1,380	41	2,589	0.00	14.00
15.00	CAH visits	0	0	0		15.00
15.10	REH hours and visits					15.10
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
26.00	RHC (CONSOLIDATED)	6,173	5,483	24,443	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	27.00
28.00	Observation Bed Days		85	579		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: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet S-3
Part I
Date/Time Prepared:
2/25/2024 7:10 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
	Nonpaid Workers					
	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	193	9	509	1.00
2.00 HMO and other (see instructions)			79	37		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	193	9	509	14.00
15.00 CAH visits						15.00
15.10 REH hours and visits						15.10
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01
34.00 Temporary Expansion COVID-19 PHE Acute Care						34.00

Health Financial Systems		MENDOTA COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1310 Component CCN: 14-8535		Period: From 10/01/2022 To 09/30/2023 Worksheet S-8 Date/Time Prepared: 2/25/2024 7:10 pm	
		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification Street	1405 E. 12TH ST.		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MENDOTA IL 61342		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	
4.00	Source of Federal Funds 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	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
				5.00	
11.00	Facility hours of operations (1) CLINIC	08:00		17:00	
		08:00		11.00	
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y		2 13.00	
		Provider name		CCN	
		1.00		2.00	
14.00	RHC/FQHC name, CCN	MENDOTA COMMUNITY HOSPITAL - RHC		148535	
14.01		OSF MEDICAL GROUP WASHINGTON STREET		148567	
		XVIII		XIX	
		3.00		4.00	
		Total Visits		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	LASALLE COUNTY		2.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1310 Component CCN: 14-8535		Period: From 10/01/2022 To 09/30/2023	Worksheet S-8 Date/Time Prepared: 2/25/2024 7:10 pm
					RHC I	Cost
		Tuesday	Wednesday		Thursday	
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00			11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1310	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/25/2024 7:10 pm
				1.00
PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)		0.291169	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		2,473,319	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		15,834,524	6.00
7.00	Medicaid cost (line 1 times line 6)		4,610,523	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		2,137,204	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		2,137,204	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	1,406,511	224,364	1,630,875
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	409,532	224,364	633,896
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (see instructions)	409,532	224,364	633,896
				1.00
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
25.01	Charges for insured patients' liability (see instructions)		0	25.01
26.00	Bad debt amount (see instructions)		1,571,875	26.00
27.00	Medicare reimbursable bad debts (see instructions)		218,269	27.00
27.01	Medicare allowable bad debts (see instructions)		335,798	27.01
28.00	Non-Medicare bad debt amount (see instructions)		1,236,077	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		477,436	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		1,111,332	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,248,536	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1310	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/25/2024 7:10 pm
				1.00
PART II - HOSPITAL DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)			1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			5.00
6.00	Medicaid charges			6.00
7.00	Medicaid cost (line 1 times line 6)			7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)			8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP			9.00
10.00	Stand-alone CHIP charges			10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)			12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			14.00
15.00	State or local indigent care program cost (line 1 times line 14)			15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)			16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care			17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)			20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)			21.00
22.00	Payments received from patients for amounts previously written off as charity care			22.00
23.00	Cost of charity care (see instructions)			23.00
				1.00
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			25.00
25.01	Charges for insured patients' liability (see instructions)			25.01
26.00	Bad debt amount (see instructions)			26.00
27.00	Medicare reimbursable bad debts (see instructions)			27.00
27.01	Medicare allowable bad debts (see instructions)			27.01
28.00	Non-Medicare bad debt amount (see instructions)			28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)			29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1310

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

Worksheet A

Date/Time Prepared:
2/25/2024 7:10 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ions (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	168,730	168,730	35,518	204,248	1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	0	0	0	0	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	473,408	473,408	39,822	513,230	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	119,782	686,789	3,387,788	4,194,359	4.00
5.01	01140	BUSINESS OFFICE	0	3,538	0	3,538	5.01
5.02	00550	DATA PROCESSING	0	6,847	1,036,946	1,043,793	5.02
5.03	00570	ADMINITTING	0	0	0	0	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	124,282	225,602	349,884	376,680	5.04
5.05	00590	OTHER A&G	629,524	6,167,301	6,796,825	5,325,952	5.05
7.00	00700	OPERATION OF PLANT	259,821	1,517,327	1,777,148	1,366,368	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,005	86,421	102,426	97,744	8.00
9.00	00900	HOUSEKEEPING	447,013	282,188	729,201	618,754	9.00
10.00	01000	DIETARY	339,274	236,827	576,101	161,555	10.00
11.00	01100	CAFETERIA	0	0	0	333,454	11.00
13.00	01300	NURSING ADMINISTRATION	186,485	58,541	245,026	262,063	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	384	384	56,652	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	269,062	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,856,455	697,738	2,554,193	-450,381	30.00
31.00	03100	INTENSIVE CARE UNIT	190,200	70,838	261,038	-34,799	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	444,234	757,067	1,201,301	-364,634	50.00
51.00	05100	RECOVERY ROOM	105,896	50,839	156,735	-31,764	51.00
53.00	05300	ANESTHESIOLOGY	223,124	-63,868	159,256	-22,666	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	392,706	130,766	523,472	296,362	54.00
54.01	05401	ULTRASOUND	8,881	330,397	339,278	-1,733	54.01
54.02	05402	MAMMOGRAPHY	122,263	40,270	162,533	-32,353	54.02
56.00	05600	RADIOISOTOPE	3,636	204,331	207,967	-24,870	56.00
57.00	05700	CT SCAN	182,774	104,959	287,733	-44,336	57.00
58.00	05800	MRI	104,878	46,347	151,225	-28,291	58.00
60.00	06000	LABORATORY	751,540	991,926	1,743,466	-178,256	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	51,262	51,262	0	63.00
64.00	06400	INTRAVENOUS THERAPY	312,040	128,126	440,166	-78,190	64.00
65.00	06500	RESPIRATORY THERAPY	476,376	181,881	658,257	-119,930	65.00
65.01	06501	SLEEP LAB	69,094	26,648	95,742	-16,219	65.01
66.00	06600	PHYSICAL THERAPY	651,400	176,270	827,670	-132,746	66.00
67.00	06700	OCCUPATIONAL THERAPY	129,610	49,196	178,806	-35,703	67.00
68.00	06800	SPEECH PATHOLOGY	40,972	11,028	52,000	-7,585	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	4,959	1,440	6,399	-1,121	69.01
69.02	06902	CARDIOLOGY	0	3,042	3,042	0	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	-36,739	-36,739	79,410	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	189,267	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	239,368	1,266,795	1,506,163	13,350	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	12	12	-12	75.00
76.00	03020	CANCER CARE CENTER	72,763	8,840	81,603	-8,074	76.00
76.97	07697	CARDIAC REHABILITATION	63,681	26,225	89,906	-24,299	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,379,857	1,806,959	5,186,816	-793,077	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,497,041	2,041,295	3,538,336	-311,142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,445,934	19,017,793	32,463,727	627,571	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	56,549	56,549	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,145	3,861	7,006	15	192.00
192.01	19201	PHYSICIAN OFFICE PRIOR TO RHC CERT	3,588,101	1,065,674	4,653,775	-588,118	192.01
194.00	07950	OTHER NRCC	4,469	-10,648	-6,179	-1,096	194.00
194.01	07951	MARKETING	0	22	22	0	194.01
194.02	07952	FOUNDATION	0	81,242	81,242	-38,372	194.02
194.03	07953	RESEARCH	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	17,041,649	20,214,493	37,256,142	0	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1310

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

Worksheet A

Date/Time Prepared:
2/25/2024 7:10 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	136,922	341,170	1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	0	0	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	241,082	754,312	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-30,217	4,164,142	4.00
5.01	01140	BUSINESS OFFICE	0	3,538	5.01
5.02	00550	DATA PROCESSING	0	1,043,793	5.02
5.03	00570	ADMINISTRATIVE	0	0	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	0	376,680	5.04
5.05	00590	OTHER A&G	-607,390	4,718,562	5.05
7.00	00700	OPERATION OF PLANT	-12,778	1,353,590	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	97,744	8.00
9.00	00900	HOUSEKEEPING	0	618,754	9.00
10.00	01000	DIETARY	0	161,555	10.00
11.00	01100	CAFETERIA	-76,745	256,709	11.00
13.00	01300	NURSING ADMINISTRATION	358,263	620,326	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	56,652	16.00
17.00	01700	SOCIAL SERVICE	-32,136	236,926	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-24,711	2,079,101	30.00
31.00	03100	INTENSIVE CARE UNIT	-2,889	223,350	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	836,667	50.00
51.00	05100	RECOVERY ROOM	4,000	128,971	51.00
53.00	05300	ANESTHESIOLOGY	-116,728	19,862	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-18,373	801,461	54.00
54.01	05401	ULTRASOUND	0	337,545	54.01
54.02	05402	MAMMOGRAPHY	0	130,180	54.02
56.00	05600	RADIOISOTOPE	0	183,097	56.00
57.00	05700	CT SCAN	0	243,397	57.00
58.00	05800	MRI	0	122,934	58.00
60.00	06000	LABORATORY	-3,527	1,561,683	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	51,262	63.00
64.00	06400	INTRAVENOUS THERAPY	0	361,976	64.00
65.00	06500	RESPIRATORY THERAPY	0	538,327	65.00
65.01	06501	SLEEP LAB	0	79,523	65.01
66.00	06600	PHYSICAL THERAPY	4,603	699,527	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,285	144,388	67.00
68.00	06800	SPEECH PATHOLOGY	288	44,703	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	0	5,278	69.01
69.02	06902	CARDIOLOGY	0	3,042	69.02
69.03	06903	PULMONARY REHAB	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	42,671	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	189,267	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-230,771	1,288,742	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	73,529	76.00
76.97	07697	CARDIAC REHABILITATION	-2,431	63,176	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-268,457	4,125,282	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-1,196,711	2,030,483	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,877,421	31,213,877	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	56,549	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-7,006	15	192.00
192.01	19201	PHYSICIAN OFFICE PRIOR TO RHC CERT	0	4,065,657	192.01
194.00	07950	OTHER NRCC	0	-7,275	194.00
194.01	07951	MARKETING	0	22	194.01
194.02	07952	FOUNDATION	0	42,870	194.02
194.03	07953	RESEARCH	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,884,427	35,371,715	200.00

RECLASSIFICATIONS

Provider CCN: 14-1310

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

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Increases					
Cost Center		Line #	Salary	Other	
2.00	3.00	4.00	5.00		
B - TO RECLASS COPIER LEASE EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	38,042	1.00
2.00		0.00	0	0	2.00
	0		0	38,042	
C - TO RECLASS BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,878,187	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
	0		0	3,878,187	
D - TO RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	229,488	103,966	1.00
	0		229,488	103,966	
F - TO RECLASS VACATION, PTO, REWARDS					
1.00	PURCHASING RECEIVING AND STORES	5.04	49	0	1.00
2.00	OTHER A&G	5.05	645	0	2.00
3.00	OPERATION OF PLANT	7.00	102	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	6	0	4.00
5.00	HOUSEKEEPING	9.00	469	0	5.00
6.00	DIETARY	10.00	134	0	6.00
7.00	NURSING ADMINISTRATION	13.00	73	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	795	0	8.00
9.00	INTENSIVE CARE UNIT	31.00	75	0	9.00
10.00	OPERATING ROOM	50.00	175	0	10.00
11.00	RECOVERY ROOM	51.00	42	0	11.00
12.00	ANESTHESIOLOGY	53.00	88	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	155	0	13.00
14.00	ULTRASOUND	54.01	3	0	14.00
15.00	MAMMOGRAPHY	54.02	48	0	15.00
16.00	RADIOISOTOPE	56.00	1	0	16.00
17.00	CT SCAN	57.00	72	0	17.00
18.00	MRI	58.00	41	0	18.00
19.00	LABORATORY	60.00	296	0	19.00
20.00	INTRAVENOUS THERAPY	64.00	123	0	20.00
21.00	RESPIRATORY THERAPY	65.00	188	0	21.00
22.00	SLEEP LAB	65.01	27	0	22.00
23.00	PHYSICAL THERAPY	66.00	257	0	23.00
24.00	OCCUPATIONAL THERAPY	67.00	51	0	24.00
25.00	SPEECH PATHOLOGY	68.00	16	0	25.00
26.00	ECHOCARDIOGRAPHY	69.01	2	0	26.00
27.00	DRUGS CHARGED TO PATIENTS	73.00	94	0	27.00
28.00	CANCER CARE CENTER	76.00	29	0	28.00
29.00	CARDIAC REHABILITATION	76.97	25	0	29.00
30.00	RURAL HEALTH CLINIC	88.00	1,332	0	30.00

RECLASSIFICATIONS

Provider CCN: 14-1310

Period:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
31.00	EMERGENCY	91.00	590	0		31.00
32.00	PHYSICIANS' PRIVATE OFFICES	192.00	1	0		32.00
33.00	PHYSICIAN OFFICE PRIOR TO RHC CERT	192.01	1,414	0		33.00
34.00	OTHER NRCC	194.00	2	0		34.00
			7,420	0		
H - TO RECLASS SHORT TERM DISABILITY						
1.00	ADULTS & PEDIATRICS	30.00	0	5,995		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	2,769		2.00
3.00	OPERATING ROOM	50.00	0	2,155		3.00
4.00	PHYSICAL THERAPY	66.00	0	3,240		4.00
	TOTALS		0	14,159		
I - TO RECLASS AUTO & OTHER PROP INSUR						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,780		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	35,518		2.00
3.00	OTHER A&G	5.05	0	480,449		3.00
			0	517,747		
J - TO RECLASS SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	50,726		1.00
	TOTALS		0	50,726		
K - TO RECLASS IMPLANTS						
1.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	189,267		1.00
			0	189,267		
L - TO RECLASS DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	30,183		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
			0	30,183		
M - MINISTRY MEDICAL RECORDS						
1.00	MEDICAL RECORDS & LIBRARY	16.00	0	56,268		1.00
			0	56,268		
N - FOUNDATION EXPENSE RECLASS						
1.00	OTHER A&G	5.05	0	37,150		1.00
2.00	DIETARY	10.00	0	413		2.00
3.00	CANCER CARE CENTER	76.00	0	809		3.00
			0	38,372		
O - TO RECLASS NURSING ADMIN SALARIES						
1.00	NURSING ADMINISTRATION	13.00	72,260	0		1.00
			72,260	0		
P - TO RECLASS ADVERTISING EXPENSE						
1.00	OTHER A&G	5.05	0	37		1.00
			0	37		
Q - TO RECLASS OTHER THERAPEUTIC SVCS						
1.00	INTRAVENOUS THERAPY	64.00	9,203	0		1.00
2.00		0.00	0	0		2.00
			9,203	0		
R - TO RECLASS RETENTION BONUS						
1.00	PURCHASING RECEIVING AND STORES	5.04	544	0		1.00
2.00	OTHER A&G	5.05	2,755	0		2.00
3.00	OPERATION OF PLANT	7.00	1,137	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	70	0		4.00
5.00	HOUSEKEEPING	9.00	1,957	0		5.00
6.00	DIETARY	10.00	1,485	0		6.00
7.00	NURSING ADMINISTRATION	13.00	1,111	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	23,698	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	833	0		9.00
10.00	OPERATING ROOM	50.00	9,768	0		10.00
11.00	RECOVERY ROOM	51.00	1,718	0		11.00
12.00	ANESTHESIOLOGY	53.00	977	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	1,719	0		13.00
14.00	ULTRASOUND	54.01	39	0		14.00
15.00	MAMMOGRAPHY	54.02	535	0		15.00
16.00	RADIOISOTOPE	56.00	16	0		16.00
17.00	CT SCAN	57.00	800	0		17.00
18.00	MRI	58.00	459	0		18.00
19.00	LABORATORY	60.00	3,290	0		19.00
20.00	INTRAVENOUS THERAPY	64.00	4,790	0		20.00
21.00	RESPIRATORY THERAPY	65.00	9,465	0		21.00
22.00	SLEEP LAB	65.01	302	0		22.00
23.00	PHYSICAL THERAPY	66.00	2,851	0		23.00
24.00	OCCUPATIONAL THERAPY	67.00	567	0		24.00

RECLASSIFICATIONS

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Period:
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		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
25.00	SPEECH PATHOLOGY	68.00	179	0		25.00
26.00	ECHOCARDIOGRAPHY	69.01	22	0		26.00
27.00	DRUGS CHARGED TO PATIENTS	73.00	1,048	0		27.00
28.00	CANCER CARE CENTER	76.00	318	0		28.00
29.00	CARDIAC REHABILITATION	76.97	279	0		29.00
30.00	RURAL HEALTH CLINIC	88.00	14,794	0		30.00
31.00	EMERGENCY	91.00	16,516	0		31.00
32.00	PHYSICIANS' PRIVATE OFFICES	192.00	14	0		32.00
33.00	PHYSICIAN OFFICE PRIOR TO RHC CERT	192.01	15,705	0		33.00
34.00	OTHER NRCC	194.00	20	0		34.00
	TOTALS		119,781	0		
S - RECLASS PREMIER CONTRACT ADMIN FEE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	28,684		1.00
	TOTALS		0	28,684		
V - RHC PHYSICIAN HOSP COSTS						
1.00	ADULTS & PEDIATRICS	30.00	7,815	0		1.00
	0		7,815	0		
X - UTILITY EXPENSE						
1.00	OPERATION OF PLANT	7.00	0	51,538		1.00
2.00	0	0.00	0	0		2.00
	0		0	51,538		
Y - CLINICAL ENGINEERING DEPT						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	396,895		1.00
2.00	LABORATORY	60.00	0	76,454		2.00
	0		0	473,349		
Z - MINISTRY RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	153,796		1.00
2.00	DATA PROCESSING	5.02	0	1,036,946		2.00
3.00	PURCHASING RECEIVING AND STORES	5.04	0	102,709		3.00
4.00	OPERATION OF PLANT	7.00	0	81,577		4.00
5.00	SOCIAL SERVICE	17.00	0	269,062		5.00
6.00	PHYSICAL THERAPY	66.00	0	16,751		6.00
7.00	OCCUPATIONAL THERAPY	67.00	0	4,675		7.00
8.00	SPEECH PATHOLOGY	68.00	0	1,048		8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	36,235		9.00
	0		0	1,702,799		
AA - TO RECLASS EXPENSES FROM ASC						
1.00	INTRAVENOUS THERAPY	64.00	0	12		1.00
	0		0	12		
AB - TO RECLASS REGIONAL ADMIN EXPENSE						
1.00	RURAL HEALTH CLINIC	88.00	0	5,605		1.00
	TOTALS		0	5,605		
500.00	Grand Total: Increases		445,967	7,178,941		500.00

RECLASSIFICATIONS

Provider CCN: 14-1310

Period:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	B - TO RECLASS COPIER LEASE EXPENSE						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	495	10		1.00
2.00	LABORATORY	60.00	0	37,547	0		2.00
	0		0	38,042			
	C - TO RECLASS BENEFITS						
1.00	PURCHASING RECEIVING AND STORES	5.04	0	47,822	0		1.00
2.00	OTHER A&G	5.05	0	154,580	0		2.00
3.00	OPERATION OF PLANT	7.00	0	71,785	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	4,758	0		4.00
5.00	HOUSEKEEPING	9.00	0	112,580	0		5.00
6.00	DIETARY	10.00	0	83,124	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	56,407	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	473,733	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	35,397	0		9.00
10.00	OPERATING ROOM	50.00	0	134,584	0		10.00
11.00	RECOVERY ROOM	51.00	0	33,524	0		11.00
12.00	ANESTHESIOLOGY	53.00	0	23,731	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	101,816	0		13.00
14.00	ULTRASOUND	54.01	0	1,775	0		14.00
15.00	MAMMOGRAPHY	54.02	0	32,936	0		15.00
16.00	RADIOISOTOPE	56.00	0	725	0		16.00
17.00	CT SCAN	57.00	0	39,283	0		17.00
18.00	MRI	58.00	0	28,791	0		18.00
19.00	LABORATORY	60.00	0	220,749	0		19.00
20.00	INTRAVENOUS THERAPY	64.00	0	92,318	0		20.00
21.00	RESPIRATORY THERAPY	65.00	0	129,583	0		21.00
22.00	SLEEP LAB	65.01	0	16,548	0		22.00
23.00	PHYSICAL THERAPY	66.00	0	152,605	0		23.00
24.00	OCCUPATIONAL THERAPY	67.00	0	40,996	0		24.00
25.00	SPEECH PATHOLOGY	68.00	0	8,828	0		25.00
26.00	ECHOCARDIOGRAPHY	69.01	0	1,145	0		26.00
27.00	DRUGS CHARGED TO PATIENTS	73.00	0	54,210	0		27.00
28.00	CANCER CARE CENTER	76.00	0	9,230	0		28.00
29.00	CARDIAC REHABILITATION	76.97	0	24,603	0		29.00
30.00	RURAL HEALTH CLINIC	88.00	0	771,598	0		30.00
31.00	EMERGENCY	91.00	0	328,211	0		31.00
32.00	PHYSICIAN OFFICE PRIOR TO RHC CERT	192.01	0	589,094	0		32.00
33.00	OTHER NRCC	194.00	0	1,118	0		33.00
	0		0	3,878,187			
	D - TO RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	229,488	103,966	0		1.00
	0		229,488	103,966			
	F - TO RECLASS VACATION, PTO, REWARDS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,667	0		1.00
2.00	OTHER A&G	5.05	0	397	0		2.00
3.00	HOUSEKEEPING	9.00	0	293	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	63	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00

RECLASSIFICATIONS

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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	0	0	0		32.00
33.00		0.00	0	0	0		33.00
34.00		0.00	0	0	0		34.00
			0	7,420			
H - TO RECLASS SHORT TERM DISABILITY							
1.00	ADULTS & PEDIATRICS	30.00	5,995	0	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	2,769	0	0		2.00
3.00	OPERATING ROOM	50.00	2,155	0	0		3.00
4.00	PHYSICAL THERAPY	66.00	3,240	0	0		4.00
	TOTALS		14,159	0			
I - TO RECLASS AUTO & OTHER PROP INSUR							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	517,747	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	0		3.00
			0	517,747			
J - TO RECLASS SUPPLIES							
1.00	OPERATING ROOM	50.00	0	50,726	0		1.00
	TOTALS		0	50,726			
K - TO RECLASS IMPLANTS							
1.00	OPERATING ROOM	50.00	0	189,267	0		1.00
			0	189,267			
L - TO RECLASS DRUGS							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	96	0		1.00
2.00	RADIOISOTOPE	56.00	0	24,162	0		2.00
3.00	CT SCAN	57.00	0	5,925	0		3.00
			0	30,183			
M - MINISTRY MEDICAL RECORDS							
1.00	OTHER A&G	5.05	0	56,268	0		1.00
			0	56,268			
N - FOUNDATION EXPENSE RECLASS							
1.00	FOUNDATION	194.02	0	38,372	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
			0	38,372			
O - TO RECLASS NURSING ADMIN SALARIES							
1.00	OTHER A&G	5.05	72,260	0	0		1.00
			72,260	0			
P - TO RECLASS ADVERTISING EXPENSE							
1.00	EMERGENCY	91.00	0	37	0		1.00
			0	37			
Q - TO RECLASS OTHER THERAPEUTIC SVCS							
1.00	ADULTS & PEDIATRICS	30.00	8,893	0	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	310	0	0		2.00
			9,203	0			
R - TO RECLASS RETENTION BONUS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	119,781	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00

RECLASSIFICATIONS

Provider CCN: 14-1310

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

Worksheet A-6

Date/Time Prepared:
2/25/2024 7:10 pm

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	0	0	0		32.00
33.00		0.00	0	0	0		33.00
34.00		0.00	0	0	0		34.00
	TOTALS		119,781	0			
	S - RECLASS PREMIER CONTRACT ADMIN FEE						
1.00	PURCHASING RECEIVING AND STORES	5.04	0	28,684	0		1.00
	TOTALS		0	28,684			
	V - RHC PHYSICIAN HOSP COSTS						
1.00	RURAL HEALTH CLINIC	88.00	7,815	0	0		1.00
	0		7,815	0			
	X - UTILITY EXPENSE						
1.00	RURAL HEALTH CLINIC	88.00	0	35,395	0		1.00
2.00	PHYSICIAN OFFICE PRIOR TO RHC CERT	192.01	0	16,143	0		2.00
	0		0	51,538			
	Y - CLINICAL ENGINEERING DEPT						
1.00	OPERATION OF PLANT	7.00	0	473,349	0		1.00
2.00	0	0.00	0	0	0		2.00
	0		0	473,349			
	Z - MINISTRY RECLASS						
1.00	OTHER A&G	5.05	0	1,702,799	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	0		0	1,702,799			
	AA - TO RECLASS EXPENSES FROM ASC						
1.00	ASC (NON-DISTINCT PART)	75.00	0	12	0		1.00
	0		0	12			
	AB - TO RECLASS REGIONAL ADMIN EXPENSE						
1.00	OTHER A&G	5.05	0	5,605	0		1.00
	TOTALS		0	5,605			
500.00	Grand Total: Decreases		452,706	7,172,202			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet A-7
Part I
Date/Time Prepared:
2/25/2024 7:10 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,927,000	500,000	0	500,000	0	1.00
2.00	Land Improvements	2,056,749	61,186	0	61,186	0	2.00
3.00	Buildings and Fixtures	16,340,581	3,072,371	0	3,072,371	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	14,636,255	338,835	0	338,835	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	34,960,585	3,972,392	0	3,972,392	0	8.00
9.00	Reconciling Items	90,658	137,371	0	137,371	0	9.00
10.00	Total (line 8 minus line 9)	34,869,927	3,835,021	0	3,835,021	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,427,000	0				1.00
2.00	Land Improvements	2,117,935	0				2.00
3.00	Buildings and Fixtures	19,412,952	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	14,975,090	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	38,932,977	0				8.00
9.00	Reconciling Items	228,029	0				9.00
10.00	Total (line 8 minus line 9)	38,704,948	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet A-7
Part II
Date/Time Prepared:
2/25/2024 7:10 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	168,730	0	0	0	0	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	473,408	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	642,138	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	168,730				1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	473,408				2.00
3.00	Total (sum of lines 1-2)	0	642,138				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet A-7
Part III
Date/Time Prepared:
2/25/2024 7:10 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	23,957,887	0	23,957,887	0.615362	0	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	14,975,090	0	14,975,090	0.384638	0	2.00
3.00	Total (sum of lines 1-2)	38,932,977	0	38,932,977	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col.s. 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	305,652	0	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	714,490	38,042	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,020,142	38,042	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 col.s. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	35,518	0	0	341,170	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,780	0	0	754,312	2.00
3.00	Total (sum of lines 1-2)	0	37,298	0	0	1,095,482	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1310

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

Worksheet A-8

Date/Time Prepared:
2/25/2024 7:10 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-OFFSITE MOBS (chapter 2)			OCAP REL COSTS-OFFSITE MOBS	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,440,442			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	798,671			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-76,121	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B		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	B	-624	CAFETERIA	11.00	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		ORESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL 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			OCAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-OFFSITE MOBS			OCAP REL COSTS-OFFSITE MOBS	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			OCAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00		30.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1310

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

Worksheet A-8

Date/Time Prepared:
2/25/2024 7:10 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
30.99	Hospice (non-distinct) (see instructions)	A-8-3		0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-190	OTHER A&G	5.05	0	33.00
33.01	MISCELLANEOUS INCOME	B	-840	NURSING ADMINISTRATION	13.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	-2,431	CARDIAC REHABILITATION	76.97	0	33.02
33.03	340B EXPENSE	B	-232,294	DRUGS CHARGED TO PATIENTS	73.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-9,600	RURAL HEALTH CLINIC	88.00	0	33.04
33.05	DONATIONS	A	-450	OTHER A&G	5.05	0	33.05
33.06	MOB PROPERTY TAXES	A	-34,165	OTHER A&G	5.05	0	33.06
33.07	MOB PROPERTY TAXES	A	-3,802	RURAL HEALTH CLINIC	88.00	0	33.07
33.08	COMMUNITY HEALTH EXPENSE - OTHER	A	-346	OTHER A&G	5.05	0	33.08
33.09	LOBBYING EXPENSE	A	-11,928	OTHER A&G	5.05	0	33.09
33.10	CRNA BENEFIT EXPENSE	A	-24,110	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	PROVIDER TAX IDPA EXPENSE	A	-1,088,403	OTHER A&G	5.05	0	33.11
33.12	NON RHC PHYSICIAN BENEFITS	A	-1,784	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	ASSET RE-LIFING	A	272,635	CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
33.14	ASSET RE-LIFING	A	-143,658	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.14
33.15	ADVERTISING	A	-2,415	OTHER A&G	5.05	0	33.15
33.16	PROMPTCARE - SALARY	A	-3,145	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.16
33.17	PROMPTCARE - OTHER	A	-3,861	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.17
33.18	PHYSICIAN PT B BENEFITS	A	-4,323	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33.19	OSFMG CRNA EXPENSE	A	109,516	ANESTHESIOLOGY	53.00	0	33.19
33.20	OSFMG HOSPITALIST EXPENSE	A	-533	ADULTS & PEDIATRICS	30.00	0	33.20
33.21	PHYSICIAN RECRUITMENT EXPENSE	A	-486	OTHER A&G	5.05	0	33.21
33.22	GUILD ADJUSTMENT	A	4,000	RECOVERY ROOM	51.00	0	33.22
33.23	MALPRACTICE EXPENSE	A	16,702	OTHER A&G	5.05	0	33.23
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,884,427				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: 14-1310

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

Worksheet A-8-1

Date/Time Prepared:
2/25/2024 7:10 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL BLDG HO BLDG CAPITA	155,147	277,419	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	384,740	0	2.00
3.00	5.05	OTHER A&G	HO POOLED - ADMIN & GENERAL	1,485,989	1,770,650	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	MINISTRY ALLOCATION	153,796	153,796	3.01
3.02	5.02	DATA PROCESSING	MINISTRY ALLOCATION	1,036,946	1,036,946	3.02
3.03	5.04	PURCHASING RECEIVING AND STO	MINISTRY ALLOCATION	102,709	102,709	3.03
3.04	7.00	OPERATION OF PLANT	MINISTRY ALLOCATION	81,698	81,698	3.04
3.05	30.00	ADULTS & PEDIATRICS	MINISTRY ALLOCATION	26,712	0	3.05
3.06	66.00	PHYSICAL THERAPY	MINISTRY ALLOCATION	21,354	16,751	3.06
3.07	67.00	OCCUPATIONAL THERAPY	MINISTRY ALLOCATION	5,960	4,675	3.07
3.08	68.00	SPEECH PATHOLOGY	MINISTRY ALLOCATION	1,336	1,048	3.08
3.09	73.00	DRUGS CHARGED TO PATIENTS	MINISTRY ALLOCATION	36,235	36,235	3.09
3.10	54.00	RADIOLOGY-DIAGNOSTIC	MINISTRY ALLOCATION	173	173	3.10
3.11	60.00	LABORATORY	MINISTRY ALLOCATION	33	33	3.11
3.12	13.00	NURSING ADMINISTRATION	HO FUNCTIONAL - NURSING ADMI	359,103	0	3.12
3.13	73.00	DRUGS CHARGED TO PATIENTS	HO FUNCTIONAL - NURSING ADMI	90,020	90,020	3.13
3.14	17.00	SOCIAL SERVICE	HO FUNCTIONAL - SOCIAL SERVI	236,926	269,062	3.14
4.00	5.05	OTHER A&G	HO FUNCTIONAL - ADMIN & GEN	1,970,970	1,171,423	4.00
4.01	73.00	DRUGS CHARGED TO PATIENTS	HO FUNCTIONAL - PHARMACY	1,523	0	4.01
4.02	5.05	OTHER A&G	RELATED PARTY SFI CVO	25,199	25,144	4.02
4.03	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY SFI EETS EQUIP	3,505	3,564	4.03
4.04	5.05	OTHER A&G	RELATED PARTY SFI HTM CONTRA	334	495	4.04
4.05	7.00	OPERATION OF PLANT	SFI HEALTHCARE TECHNOLOGY SV	264,143	276,921	4.05
4.06	54.00	RADIOLOGY-DIAGNOSTIC	SFI HEALTHCARE TECHNOLOGY SV	378,574	396,888	4.06
4.07	60.00	LABORATORY	SFI HEALTHCARE TECHNOLOGY SV	72,924	76,451	4.07
4.08	31.00	INTENSIVE CARE UNIT	EICU	5,198	8,087	4.08
4.09	5.05	OTHER A&G	PURCH SVCS-ST GABRIEL	207,571	208,060	4.09
4.10	1.00	CAP REL COSTS-BLDG & FIXT	OSFMG MINISTRY ALLOCATION	709	14,150	4.10
4.11	30.00	ADULTS & PEDIATRICS	OSFMG MINISTRY ALLOCATION	388	6,088	4.11
4.12	53.00	ANESTHESIOLOGY	OSFMG MINISTRY ALLOCATION	212	3,332	4.12
4.13	88.00	RURAL HEALTH CLINIC	OSFMG MINISTRY ALLOCATION	322,699	577,754	4.13
4.14	91.00	EMERGENCY	OSFMG MINISTRY ALLOCATION	1,671	26,254	4.14
5.00	TOTALS (sum of lines 1-4).			7,434,497	6,635,826	5.00
	Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.					

* 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.

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME
OFFICE COSTS

Provider CCN: 14-1310

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

Worksheet A-8-1

Date/Time Prepared:
2/25/2024 7:10 pm

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
				Name	Percentage of Ownership
	1.00	2.00	3.00	4.00	5.00

(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: 14-1310

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

Worksheet A-8-1

Date/Time Prepared:
2/25/2024 7:10 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	-122,272	9		1.00
2.00	384,740	9		2.00
3.00	-284,661	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	26,712	0		3.05
3.06	4,603	0		3.06
3.07	1,285	0		3.07
3.08	288	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	359,103	0		3.12
3.13	0	0		3.13
3.14	-32,136	0		3.14
4.00	799,547	0		4.00
4.01	1,523	0		4.01
4.02	55	0		4.02
4.03	-59	0		4.03
4.04	-161	0		4.04
4.05	-12,778	0		4.05
4.06	-18,314	0		4.06
4.07	-3,527	0		4.07
4.08	-2,889	0		4.08
4.09	-489	0		4.09
4.10	-13,441	9		4.10
4.11	-5,700	0		4.11
4.12	-3,120	0		4.12
4.13	-255,055	0		4.13
4.14	-24,583	0		4.14
5.00	798,671			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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1310

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

Worksheet A-8-2

Date/Time Prepared:
2/25/2024 7:10 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	5.05	OTHER A&G	80,592	0	80,592	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	45,190	45,190	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	223,124	223,124	0	0	0	3.00
4.00	60.00	LABORATORY	16,620	0	16,620	0	0	4.00
5.00	91.00	EMERGENCY	1,448,502	1,172,128	276,374	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			1,814,028	1,440,442	373,586		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	5.05	OTHER A&G	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	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	5.05	OTHER A&G	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	45,190		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	223,124		3.00
4.00	60.00	LABORATORY	0	0	0	0		4.00
5.00	91.00	EMERGENCY	0	0	0	1,172,128		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	1,440,442		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet B
Part I
Date/Time Prepared:
2/25/2024 7:10 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	341,170	341,170			1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	0	0	0		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	754,312		754,312		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,164,142	459	0	4,164,601	4.00
5.01	01140	BUSINESS OFFICE	3,538	4,330	0	248	5.01
5.02	00550	DATA PROCESSING	1,043,793	5,057	0	18,481	5.02
5.03	00570	ADMINISTRATIVE	0	2,670	0	232	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	376,680	1,185	0	257	5.04
5.05	00590	OTHER A&G	4,718,562	63,384	0	20,461	5.05
7.00	00700	OPERATION OF PLANT	1,353,590	14,597	0	37,159	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	97,744	1,543	0	0	8.00
9.00	00900	HOUSEKEEPING	618,754	3,562	0	2,153	9.00
10.00	01000	DIETARY	161,555	8,859	0	20,634	10.00
11.00	01100	CAFETERIA	256,709	3,497	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	620,326	1,156	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	56,652	2,888	0	147	16.00
17.00	01700	SOCIAL SERVICE	236,926	974	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,079,101	49,741	0	108,670	30.00
31.00	03100	INTENSIVE CARE UNIT	223,350	7,534	0	2,104	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	836,667	14,232	0	178,922	50.00
51.00	05100	RECOVERY ROOM	128,971	15,967	0	0	51.00
53.00	05300	ANESTHESIOLOGY	19,862	420	0	27,818	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	801,461	10,911	0	54,542	54.00
54.01	05401	ULTRASOUND	337,545	684	0	0	54.01
54.02	05402	MAMMOGRAPHY	130,180	475	0	17,134	54.02
56.00	05600	RADIOISOTOPE	183,097	2,237	0	0	56.00
57.00	05700	CT SCAN	243,397	1,508	0	46,211	57.00
58.00	05800	MRI	122,934	3,376	0	0	58.00
60.00	06000	LABORATORY	1,561,683	5,835	0	64,520	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	51,262	345	0	4,388	63.00
64.00	06400	INTRAVENOUS THERAPY	361,976	14,626	0	1,199	64.00
65.00	06500	RESPIRATORY THERAPY	538,327	4,542	0	25,127	65.00
65.01	06501	SLEEP LAB	79,523	778	0	6,132	65.01
66.00	06600	PHYSICAL THERAPY	699,527	6,818	0	4,138	66.00
67.00	06700	OCCUPATIONAL THERAPY	144,388	889	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	44,703	329	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	5,278	381	0	0	69.01
69.02	06902	CARDIOLOGY	3,042	332	0	17,994	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	42,671	9,107	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	189,267	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,288,742	2,575	0	42,032	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	73,529	710	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	63,176	1,729	0	4,894	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	4,125,282	27,321	0	11,892	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,030,483	16,111	0	35,762	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							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,213,877	313,674	0	753,251	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	56,549	788	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15	10,614	0	0	192.00
192.01	19201	PHYSICIAN OFFICE PRIOR TO RHC CERT	4,065,657	15,710	0	0	192.01
194.00	07950	OTHER NRCC	-7,275	0	0	1,061	194.00
194.01	07951	MARKETING	22	192	0	0	194.01
194.02	07952	FOUNDATION	42,870	192	0	0	194.02

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 14-1310		Period: From 10/01/2022 To 09/30/2023		Worksheet B Part I Date/Time Prepared: 2/25/2024 7:10 pm	
Cost Center Description				Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
					BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP		
					0	1.00	1.01		
194.03	07953	RESEARCH	0	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments							200.00
201.00		Negative Cost Centers		0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	35,371,715	341,170	0	754,312	4,164,601		202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:

From 10/01/2022

To 09/30/2023

Worksheet B

Part I

Date/Time Prepared:
2/25/2024 7:10 pm

Cost Center Description			Subtotal	BUSINESS OFFICE	DATA PROCESSING	Subtotal	ADMINISTRATIVE	
			4A	5.01	5.02	5A.02	5.03	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE	8,116	8,116				5.01
5.02	00550	DATA PROCESSING	1,067,331	245	1,067,576			5.02
5.03	00570	ADMINISTRATIVE	2,902	1	0	2,903	2,903	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	409,145	94	2,449	411,688	40	5.04
5.05	00590	OTHER A&G	4,941,695	1,137	156,708	5,099,540	485	5.05
7.00	00700	OPERATION OF PLANT	1,470,202	338	0	1,470,540	143	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	103,282	24	0	103,306	10	8.00
9.00	00900	HOUSEKEEPING	736,124	169	3,673	739,966	72	9.00
10.00	01000	DIETARY	218,725	50	0	218,775	21	10.00
11.00	01100	CAFETERIA	317,218	73	0	317,291	31	11.00
13.00	01300	NURSING ADMINISTRATION	686,057	158	12,243	698,458	68	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	59,687	14	0	59,701	6	16.00
17.00	01700	SOCIAL SERVICE	237,900	55	0	237,955	23	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,691,818	619	210,577	2,903,014	282	30.00
31.00	03100	INTENSIVE CARE UNIT	279,701	64	0	279,765	27	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,142,118	263	0	1,142,381	111	50.00
51.00	05100	RECOVERY ROOM	171,683	39	2,449	174,171	17	51.00
53.00	05300	ANESTHESIOLOGY	48,365	11	30,607	78,983	8	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	964,941	222	82,027	1,047,190	102	54.00
54.01	05401	ULTRASOUND	340,446	78	0	340,524	33	54.01
54.02	05402	MAMMOGRAPHY	178,308	41	0	178,349	17	54.02
56.00	05600	RADIOISOTOPE	186,242	43	0	186,285	18	56.00
57.00	05700	CT SCAN	336,740	77	0	336,817	33	57.00
58.00	05800	MRI	152,489	35	0	152,524	15	58.00
60.00	06000	LABORATORY	1,819,636	419	138,344	1,958,399	190	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	55,995	13	0	56,008	5	63.00
64.00	06400	INTRAVENOUS THERAPY	458,829	106	153,036	611,971	59	64.00
65.00	06500	RESPIRATORY THERAPY	688,742	158	0	688,900	67	65.00
65.01	06501	SLEEP LAB	103,680	24	0	103,704	10	65.01
66.00	06600	PHYSICAL THERAPY	872,279	201	13,467	885,947	86	66.00
67.00	06700	OCCUPATIONAL THERAPY	177,630	41	0	177,671	17	67.00
68.00	06800	SPEECH PATHOLOGY	55,259	13	0	55,272	5	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	6,897	2	0	6,899	1	69.01
69.02	06902	CARDIOLOGY	21,368	5	0	21,373	2	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	51,778	12	0	51,790	5	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	189,267	44	0	189,311	18	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,393,100	320	0	1,393,420	135	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	92,402	21	0	92,423	9	76.00
76.97	07697	CARDIAC REHABILITATION	85,695	20	0	85,715	8	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,006,228	1,155	233,837	5,241,220	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,458,520	565	28,159	2,487,244	241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			0		92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,288,540	6,969	1,067,576	30,287,393	2,420	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	57,337	0	0	57,337	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,633	2	0	10,635	0	192.00
192.01	19201	PHYSICIAN OFFICE PRIOR TO RHC CERT	4,977,027	1,145	0	4,978,172	483	192.01
194.00	07950	OTHER NRCC	-5,098	0	0	-5,098	0	194.00
194.01	07951	MARKETING	214	0	0	214	0	194.01
194.02	07952	FOUNDATION	43,062	0	0	43,062	0	194.02
194.03	07953	RESEARCH	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments	0			0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	35,371,715	8,116	1,067,576	35,371,715	2,903	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet B
Part I
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Cost Center Description			PURCHASING RECEIVING AND STORES	Subtotal	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5. 04	5A. 04	5. 05	7. 00	8. 00	
GENERAL SERVICE COST CENTERS								
1. 00	00100	CAP REL COSTS-BLDG & FIXT						1. 00
1. 01	00101	CAP REL COSTS-OFFSITE MOBS						1. 01
2. 00	00200	CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01140	BUSINESS OFFICE						5. 01
5. 02	00550	DATA PROCESSING						5. 02
5. 03	00570	ADMINITTING						5. 03
5. 04	00560	PURCHASING RECEIVING AND STORES	411,728					5. 04
5. 05	00590	OTHER A&G	3,423	5,103,448	5,103,448			5. 05
7. 00	00700	OPERATION OF PLANT	1,402	1,472,085	248,163	1,720,248		7. 00
8. 00	00800	LAUNDRY & LINEN SERVICE	0	103,316	17,417	10,641	131,374	8. 00
9. 00	00900	HOUSEKEEPING	29,801	769,839	129,779	24,561	0	9. 00
10. 00	01000	DIETARY	2,407	221,203	37,290	61,087	0	10. 00
11. 00	01100	CAFETERIA	5,032	322,354	54,342	24,112	0	11. 00
13. 00	01300	NURSING ADMINISTRATION	60	698,586	117,767	7,970	0	13. 00
16. 00	01600	MEDICAL RECORDS & LIBRARY	168	59,875	10,094	19,913	0	16. 00
17. 00	01700	SOCIAL SERVICE	0	237,978	40,118	6,713	0	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS								
30. 00	03000	ADULTS & PEDIATRICS	35,619	2,938,915	495,439	342,969	33,687	30. 00
31. 00	03100	INTENSIVE CARE UNIT	6,595	286,387	48,279	51,950	1,142	31. 00
ANCILLARY SERVICE COST CENTERS								
50. 00	05000	OPERATING ROOM	73,297	1,215,789	204,956	98,130	5,446	50. 00
51. 00	05100	RECOVERY ROOM	6,599	180,787	30,477	110,096	665	51. 00
53. 00	05300	ANESTHESIOLOGY	6,784	85,775	14,460	2,896	0	53. 00
54. 00	05400	RADIOLOGY-DIAGNOSTIC	4,705	1,051,997	177,345	75,231	3,577	54. 00
54. 01	05401	ULTRASOUND	7,646	348,203	58,700	4,715	2,141	54. 01
54. 02	05402	MAMMOGRAPHY	476	178,842	30,149	3,278	1,723	54. 02
56. 00	05600	RADIOISOTOPE	688	186,991	31,523	15,423	1,187	56. 00
57. 00	05700	CT SCAN	20,536	357,386	60,248	10,394	17,210	57. 00
58. 00	05800	MRI	5,391	157,930	26,624	23,281	4,236	58. 00
60. 00	06000	LABORATORY	39,028	1,997,617	336,756	40,231	0	60. 00
63. 00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	56,013	9,443	2,380	0	63. 00
64. 00	06400	INTRAVENOUS THERAPY	12,694	624,724	105,315	100,846	0	64. 00
65. 00	06500	RESPIRATORY THERAPY	22,313	711,280	119,907	31,318	1,425	65. 00
65. 01	06501	SLEEP LAB	3,744	107,458	18,115	5,366	0	65. 01
66. 00	06600	PHYSICAL THERAPY	3,426	889,459	149,944	47,011	7,712	66. 00
67. 00	06700	OCCUPATIONAL THERAPY	396	178,084	30,021	6,129	1,574	67. 00
68. 00	06800	SPEECH PATHOLOGY	388	55,665	9,384	2,267	0	68. 00
69. 00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69. 00
69. 01	06901	ECHOCARDIOGRAPHY	133	7,033	1,186	2,627	0	69. 01
69. 02	06902	CARDIOLOGY	1,140	22,515	3,796	2,290	0	69. 02
69. 03	06903	PULMONARY REHAB	0	0	0	0	0	69. 03
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	51,795	8,732	62,793	0	71. 00
72. 00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	189,329	31,917	0	0	72. 00
73. 00	07300	DRUGS CHARGED TO PATIENTS	6,327	1,399,882	235,991	17,758	0	73. 00
75. 00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 00	03020	CANCER CARE CENTER	41	92,473	15,589	4,894	0	76. 00
76. 97	07697	CARDIAC REHABILITATION	399	86,122	14,518	11,921	0	76. 97
77. 00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
78. 00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS								
88. 00	08800	RURAL HEALTH CLINIC	15,787	5,257,007	886,212	188,380	1,011	88. 00
90. 00	09000	CLINIC	0	0	0	0	0	90. 00
91. 00	09100	EMERGENCY	65,223	2,552,708	430,333	111,084	48,638	91. 00
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92. 00
OTHER REIMBURSABLE COST CENTERS								
102. 00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS								
113. 00	11300	INTEREST EXPENSE						113. 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	381,668	30,256,850	4,240,329	1,530,655	131,374	118. 00
NONREIMBURSABLE COST CENTERS								
190. 00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	24,426	81,763	13,784	5,433	0	190. 00
192. 00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,635	1,793	73,188	0	192. 00
192. 01	19201	PHYSICIAN OFFICE PRIOR TO RHC CERT	5,624	4,984,279	840,245	108,322	0	192. 01
194. 00	07950	OTHER NRCC	0	-5,098	0	0	0	194. 00
194. 01	07951	MARKETING	10	224	38	1,325	0	194. 01
194. 02	07952	FOUNDATION	0	43,062	7,259	1,325	0	194. 02
194. 03	07953	RESEARCH	0	0	0	0	0	194. 03
200. 00		Cross Foot Adjustments	0	0	0	0	0	200. 00
201. 00		Negative Cost Centers	0	0	0	0	0	201. 00
202. 00		TOTAL (sum lines 118 through 201)	411,728	35,371,715	5,103,448	1,720,248	131,374	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:

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

Worksheet B

Part I
Date/Time Prepared:
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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	924,179					9.00
10.00	01000	DIETARY	0	319,580				10.00
11.00	01100	CAFETERIA	10,160	0	410,968			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	5,987	830,310		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,431	0	0	0	101,313	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	227,764	290,953	64,485	388,972	20,263	30.00
31.00	03100	INTENSIVE CARE UNIT	26,248	3,439	3,917	23,624	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	57,999	0	13,988	84,378	0	50.00
51.00	05100	RECOVERY ROOM	65,196	3,203	3,721	22,399	16,886	51.00
53.00	05300	ANESTHESIOLOGY	0	0	1,986	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,372	1,484	15,247	0	1,689	54.00
54.01	05401	ULTRASOUND	2,540	0	224	0	1,055	54.01
54.02	05402	MAMMOGRAPHY	1,693	0	4,392	0	844	54.02
56.00	05600	RADIOISOTOPE	8,044	0	84	0	633	56.00
57.00	05700	CT SCAN	5,504	0	6,826	0	8,021	57.00
58.00	05800	MRI	12,277	0	3,245	0	1,900	58.00
60.00	06000	LABORATORY	40,219	0	31,837	0	11,820	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	38,525	0	12,030	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	16,934	0	16,618	0	0	65.00
65.01	06501	SLEEP LAB	0	0	2,910	0	0	65.01
66.00	06600	PHYSICAL THERAPY	74,087	0	18,912	0	10,765	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,737	0	4,112	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,511	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	0	0	112	738	0	69.01
69.02	06902	CARDIOLOGY	0	0	0	0	0	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,963	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,927	0	6,882	41,431	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	0	2,014	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	2,798	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	99,065	0	75,226	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	129,969	20,501	44,566	268,768	27,437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	885,654	319,580	343,630	830,310	101,313	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	38,525	0	0	0	0	192.00
192.01	19201	PHYSICIAN OFFICE PRIOR TO RHC CERT	0	0	67,198	0	0	192.01
194.00	07950	OTHER NRCC	0	0	140	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	RESEARCH	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	924,179	319,580	410,968	830,310	101,313	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01140	BUSINESS OFFICE					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00570	ADMITTING					5.03
5.04	00560	PURCHASING RECEIVING AND STORES					5.04
5.05	00590	OTHER A&G					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	284,809				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	284,809	5,088,256	0	5,088,256	30.00
31.00	03100	INTENSIVE CARE UNIT	0	444,986	0	444,986	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,680,686	0	1,680,686	50.00
51.00	05100	RECOVERY ROOM	0	433,430	0	433,430	51.00
53.00	05300	ANESTHESIOLOGY	0	105,117	0	105,117	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,365,942	0	1,365,942	54.00
54.01	05401	ULTRASOUND	0	417,578	0	417,578	54.01
54.02	05402	MAMMOGRAPHY	0	220,921	0	220,921	54.02
56.00	05600	RADIOISOTOPE	0	243,885	0	243,885	56.00
57.00	05700	CT SCAN	0	465,589	0	465,589	57.00
58.00	05800	MRI	0	229,493	0	229,493	58.00
60.00	06000	LABORATORY	0	2,458,480	0	2,458,480	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	67,836	0	67,836	63.00
64.00	06400	INTRAVENOUS THERAPY	0	881,440	0	881,440	64.00
65.00	06500	RESPIRATORY THERAPY	0	897,482	0	897,482	65.00
65.01	06501	SLEEP LAB	0	133,849	0	133,849	65.01
66.00	06600	PHYSICAL THERAPY	0	1,197,890	0	1,197,890	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	229,657	0	229,657	67.00
68.00	06800	SPEECH PATHOLOGY	0	68,827	0	68,827	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	0	11,696	0	11,696	69.01
69.02	06902	CARDIOLOGY	0	28,601	0	28,601	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	126,283	0	126,283	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	221,246	0	221,246	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,707,871	0	1,707,871	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	114,970	0	114,970	76.00
76.97	07697	CARDIAC REHABILITATION	0	115,359	0	115,359	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	6,506,901	0	6,506,901	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	3,634,004	0	3,634,004	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	284,809	29,098,275	0	29,098,275	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	100,980	0	100,980	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	124,141	0	124,141	192.00
192.01	19201	PHYSICIAN OFFICE PRIOR TO RHC CERT	0	6,000,044	0	6,000,044	192.01
194.00	07950	OTHER NRCC	0	-4,958	0	-4,958	194.00
194.01	07951	MARKETING	0	1,587	0	1,587	194.01
194.02	07952	FOUNDATION	0	51,646	0	51,646	194.02
194.03	07953	RESEARCH	0	0	0	0	194.03
200.00		Cross Foot Adjustments		0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 14-1310		Period: From 10/01/2022 To 09/30/2023		Worksheet B Part I Date/Time Prepared: 2/25/2024 7:10 pm	
Cost Center Description				SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
				17.00	24.00	25.00	26.00		
201.00		Negative Cost Centers		0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)		284,809	35,371,715	0	35,371,715		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet B
Part II
Date/Time Prepared:
2/25/2024 7:10 pm

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
				BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP		
			0	1.00	1.01	2.00	2A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	459	0	0	459	4.00
5.01	01140	BUSINESS OFFICE	0	4,330	0	248	4,578	5.01
5.02	00550	DATA PROCESSING	0	5,057	0	18,481	23,538	5.02
5.03	00570	ADMIN TTING	0	2,670	0	232	2,902	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	0	1,185	0	257	1,442	5.04
5.05	00590	OTHER A&G	0	63,384	0	20,461	83,845	5.05
7.00	00700	OPERATION OF PLANT	0	14,597	0	37,159	51,756	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,543	0	0	1,543	8.00
9.00	00900	HOUSEKEEPING	0	3,562	0	2,153	5,715	9.00
10.00	01000	DI ETARY	0	8,859	0	20,634	29,493	10.00
11.00	01100	CAFETERIA	0	3,497	0	0	3,497	11.00
13.00	01300	NURSING ADMINI STRATION	0	1,156	0	0	1,156	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,888	0	147	3,035	16.00
17.00	01700	SOCIAL SERVICE	0	974	0	0	974	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	49,741	0	108,670	158,411	30.00
31.00	03100	INTENSIVE CARE UNIT	0	7,534	0	2,104	9,638	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	14,232	0	178,922	193,154	50.00
51.00	05100	RECOVERY ROOM	0	15,967	0	0	15,967	51.00
53.00	05300	ANESTHESIOLOGY	0	420	0	27,818	28,238	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,911	0	54,542	65,453	54.00
54.01	05401	ULTRASOUND	0	684	0	0	684	54.01
54.02	05402	MAMMOGRAPHY	0	475	0	17,134	17,609	54.02
56.00	05600	RADIOI SOTOPE	0	2,237	0	0	2,237	56.00
57.00	05700	CT SCAN	0	1,508	0	46,211	47,719	57.00
58.00	05800	MRI	0	3,376	0	0	3,376	58.00
60.00	06000	LABORATORY	0	5,835	0	64,520	70,355	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	345	0	4,388	4,733	63.00
64.00	06400	INTRAVENOUS THERAPY	0	14,626	0	1,199	15,825	64.00
65.00	06500	RESPI RATORY THERAPY	0	4,542	0	25,127	29,669	65.00
65.01	06501	SLEEP LAB	0	778	0	6,132	6,910	65.01
66.00	06600	PHYSICAL THERAPY	0	6,818	0	4,138	10,956	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	889	0	0	889	67.00
68.00	06800	SPEECH PATHOLOGY	0	329	0	0	329	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	0	381	0	0	381	69.01
69.02	06902	CARDIOLOGY	0	332	0	17,994	18,326	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,107	0	0	9,107	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,575	0	42,032	44,607	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	710	0	0	710	76.00
76.97	07697	CARDIAC REHABI LITATION	0	1,729	0	4,894	6,623	76.97
77.00	07700	ALLOGENEIC HSCT ACQUI SITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINI C	0	27,321	0	11,892	39,213	88.00
90.00	09000	CLINI C	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	16,111	0	35,762	51,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	313,674	0	753,251	1,066,925	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	788	0	0	788	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,614	0	0	10,614	192.00
192.01	19201	PHYSICIAN OFFICE PRIOR TO RHC CERT	0	15,710	0	0	15,710	192.01
194.00	07950	OTHER NRCC	0	0	0	1,061	1,061	194.00
194.01	07951	MARKETI NG	0	192	0	0	192	194.01
194.02	07952	FOUNDATION	0	192	0	0	192	194.02
194.03	07953	RESEARCH	0	0	0	0	0	194.03

ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 14-1310		Period: From 10/01/2022 To 09/30/2023	Worksheet B Part II Date/Time Prepared: 2/25/2024 7:10 pm	
Cost Center Description				CAPITAL RELATED COSTS			Subtotal	
				BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP		
				Directly Assigned New Capital Related Costs				
200.00		Cross Foot Adjustments	0	1.00	1.01	2.00	2A	
201.00		Negative Cost Centers		0	0	0		0 200.00
202.00		TOTAL (sum lines 118 through 201)	0	341,170	0	754,312	1,095,482	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet B
Part II
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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	BUSINESS OFFICE	DATA PROCESSING	ADMINING	PURCHASING RECEIVING AND STORES	
			4.00	5.01	5.02	5.03	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	459					4.00
5.01	01140	BUSINESS OFFICE	0	4,578				5.01
5.02	00550	DATA PROCESSING	0	139	23,677			5.02
5.03	00570	ADMINING	0	0	0	2,902		5.03
5.04	00560	PURCHASING RECEIVING AND STORES	3	53	54	40	1,592	5.04
5.05	00590	OTHER A&G	15	642	3,476	484	13	5.05
7.00	00700	OPERATION OF PLANT	7	191	0	143	5	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	13	0	10	0	8.00
9.00	00900	HOUSEKEEPING	12	96	81	72	115	9.00
10.00	01000	DIETARY	3	28	0	21	9	10.00
11.00	01100	CAFETERIA	6	41	0	31	19	11.00
13.00	01300	NURSING ADMINISTRATION	7	89	272	68	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8	0	6	1	16.00
17.00	01700	SOCIAL SERVICE	0	31	0	23	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	49	350	4,670	282	138	30.00
31.00	03100	INTENSIVE CARE UNIT	5	36	0	27	25	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12	148	0	111	286	50.00
51.00	05100	RECOVERY ROOM	3	22	54	17	26	51.00
53.00	05300	ANESTHESIOLOGY	0	6	679	8	26	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11	125	1,819	102	18	54.00
54.01	05401	ULTRASOUND	0	44	0	33	30	54.01
54.02	05402	MAMMOGRAPHY	3	23	0	17	2	54.02
56.00	05600	RADIOISOTOPE	0	24	0	18	3	56.00
57.00	05700	CT SCAN	5	44	0	33	79	57.00
58.00	05800	MRI	3	20	0	15	21	58.00
60.00	06000	LABORATORY	20	237	3,068	190	151	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	7	0	5	0	63.00
64.00	06400	INTRAVENOUS THERAPY	9	60	3,394	59	49	64.00
65.00	06500	RESPIRATORY THERAPY	13	90	0	67	86	65.00
65.01	06501	SLEEP LAB	2	13	0	10	14	65.01
66.00	06600	PHYSICAL THERAPY	18	113	299	86	13	66.00
67.00	06700	OCCUPATIONAL THERAPY	4	23	0	17	2	67.00
68.00	06800	SPEECH PATHOLOGY	1	7	0	5	1	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	0	1	0	1	1	69.01
69.02	06902	CARDIOLOGY	0	3	0	2	4	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7	0	5	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	25	0	18	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6	181	0	135	24	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	2	12	0	9	0	76.00
76.97	07697	CARDIAC REHABILITATION	2	11	0	8	2	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	91	647	5,186	0	61	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	41	320	625	241	252	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	353	3,930	23,677	2,419	1,476	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	94	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1	0	0	0	192.00
192.01	19201	PHYSICIAN OFFICE PRIOR TO RHC CERT	106	647	0	483	22	192.01
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	RESEARCH	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	459	4,578	23,677	2,902	1,592	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet B
Part II
Date/Time Prepared:
2/25/2024 7:10 pm

Cost Center Description			OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.05	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G	88,475					5.05
7.00	00700	OPERATION OF PLANT	4,303	56,405				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	302	349	2,217			8.00
9.00	00900	HOUSEKEEPING	2,250	805	0	9,146		9.00
10.00	01000	DIETARY	647	2,003	0	0	32,204	10.00
11.00	01100	CAFETERIA	942	791	0	101	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,042	261	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	175	653	0	113	0	16.00
17.00	01700	SOCIAL SERVICE	696	220	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,590	11,247	568	2,255	29,318	30.00
31.00	03100	INTENSIVE CARE UNIT	837	1,703	19	260	347	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,554	3,218	92	574	0	50.00
51.00	05100	RECOVERY ROOM	528	3,610	11	645	323	51.00
53.00	05300	ANESTHESIOLOGY	251	95	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,075	2,467	60	390	150	54.00
54.01	05401	ULTRASOUND	1,018	155	36	25	0	54.01
54.02	05402	MAMMOGRAPHY	523	107	29	17	0	54.02
56.00	05600	RADIOISOTOPE	547	506	20	80	0	56.00
57.00	05700	CT SCAN	1,045	341	290	54	0	57.00
58.00	05800	MRI	462	763	71	121	0	58.00
60.00	06000	LABORATORY	5,839	1,319	0	398	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	164	78	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	1,826	3,307	0	381	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,079	1,027	24	168	0	65.00
65.01	06501	SLEEP LAB	314	176	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	2,600	1,541	130	733	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	521	201	27	96	0	67.00
68.00	06800	SPEECH PATHOLOGY	163	74	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	21	86	0	0	0	69.01
69.02	06902	CARDIOLOGY	66	75	0	0	0	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	151	2,059	0	29	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	553	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,092	582	0	59	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	270	160	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	252	391	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	15,349	6,177	17	980	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	7,462	3,642	823	1,286	2,066	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,509	50,189	2,217	8,765	32,204	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	239	178	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	31	2,400	0	381	0	192.00
192.01	19201	PHYSICIAN OFFICE PRIOR TO RHC CERT	14,569	3,552	0	0	0	192.01
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	1	43	0	0	0	194.01
194.02	07952	FOUNDATION	126	43	0	0	0	194.02
194.03	07953	RESEARCH	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	88,475	56,405	2,217	9,146	32,204	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet B
Part II
Date/Time Prepared:
2/25/2024 7:10 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			11.00	13.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
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	5,428					11.00
13.00	01300	NURSING ADMINISTRATION	79	3,974				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	3,991			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	1,944		17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	852	1,862	798	1,944	221,334	30.00
31.00	03100	INTENSIVE CARE UNIT	52	113	0	0	13,062	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	185	404	0	0	201,738	50.00
51.00	05100	RECOVERY ROOM	49	107	665	0	22,027	51.00
53.00	05300	ANESTHESIOLOGY	26	0	0	0	29,329	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	201	0	67	0	73,938	54.00
54.01	05401	ULTRASOUND	3	0	42	0	2,070	54.01
54.02	05402	MAMMOGRAPHY	58	0	33	0	18,421	54.02
56.00	05600	RADIOISOTOPE	1	0	25	0	3,461	56.00
57.00	05700	CT SCAN	90	0	316	0	50,016	57.00
58.00	05800	MRI	43	0	75	0	4,970	58.00
60.00	06000	LABORATORY	420	0	466	0	82,463	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	4,987	63.00
64.00	06400	INTRAVENOUS THERAPY	159	0	0	0	25,069	64.00
65.00	06500	RESPIRATORY THERAPY	219	0	0	0	33,442	65.00
65.01	06501	SLEEP LAB	38	0	0	0	7,477	65.01
66.00	06600	PHYSICAL THERAPY	250	0	424	0	17,163	66.00
67.00	06700	OCCUPATIONAL THERAPY	54	0	0	0	1,834	67.00
68.00	06800	SPEECH PATHOLOGY	20	0	0	0	600	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	1	4	0	0	496	69.01
69.02	06902	CARDIOLOGY	0	0	0	0	18,476	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	11,358	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	596	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	91	198	0	0	49,975	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	27	0	0	0	1,190	76.00
76.97	07697	CARDIAC REHABILITATION	37	0	0	0	7,326	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	994	0	0	0	68,715	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	589	1,286	1,080	0	71,586	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,538	3,974	3,991	1,944	1,043,119	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	1,299	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	13,427	192.00
192.01	19201	PHYSICIAN OFFICE PRIOR TO RHC CERT	888	0	0	0	35,977	192.01
194.00	07950	OTHER NRCC	2	0	0	0	1,063	194.00
194.01	07951	MARKETING	0	0	0	0	236	194.01
194.02	07952	FOUNDATION	0	0	0	0	361	194.02
194.03	07953	RESEARCH	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,428	3,974	3,991	1,944	1,095,482	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet B
Part II
Date/Time Prepared:
2/25/2024 7:10 pm

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	01140	BUSINESS OFFICE			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00570	ADMITTING			5.03
5.04	00560	PURCHASING RECEIVING AND STORES			5.04
5.05	00590	OTHER A&G			5.05
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	221,334	30.00
31.00	03100	INTENSIVE CARE UNIT	0	13,062	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	201,738	50.00
51.00	05100	RECOVERY ROOM	0	22,027	51.00
53.00	05300	ANESTHESIOLOGY	0	29,329	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	73,938	54.00
54.01	05401	ULTRASOUND	0	2,070	54.01
54.02	05402	MAMMOGRAPHY	0	18,421	54.02
56.00	05600	RADIOISOTOPE	0	3,461	56.00
57.00	05700	CT SCAN	0	50,016	57.00
58.00	05800	MRI	0	4,970	58.00
60.00	06000	LABORATORY	0	82,463	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	4,987	63.00
64.00	06400	INTRAVENOUS THERAPY	0	25,069	64.00
65.00	06500	RESPIRATORY THERAPY	0	33,442	65.00
65.01	06501	SLEEP LAB	0	7,477	65.01
66.00	06600	PHYSICAL THERAPY	0	17,163	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,834	67.00
68.00	06800	SPEECH PATHOLOGY	0	600	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	0	496	69.01
69.02	06902	CARDIOLOGY	0	18,476	69.02
69.03	06903	PULMONARY REHAB	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,358	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	596	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	49,975	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	1,190	76.00
76.97	07697	CARDIAC REHABILITATION	0	7,326	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	68,715	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	71,586	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	102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,043,119	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,299	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	13,427	192.00
192.01	19201	PHYSICIAN OFFICE PRIOR TO RHC CERT	0	35,977	192.01
194.00	07950	OTHER NRCC	0	1,063	194.00
194.01	07951	MARKETING	0	236	194.01
194.02	07952	FOUNDATION	0	361	194.02
194.03	07953	RESEARCH	0	0	194.03
200.00		Cross Foot Adjustments	0	0	200.00

ALLOCATION OF CAPITAL RELATED COSTS					Provider CCN: 14-1310		Period: From 10/01/2022 To 09/30/2023		Worksheet B Part II Date/Time Prepared: 2/25/2024 7:10 pm	
Cost Center Description					Intern & Residents Cost & Post Stepdown Adjustments	Total				
201.00					0	26.00				
202.00					0	1,095,482				

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1310

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

Worksheet B-1

Date/Time Prepared:
2/25/2024 7:10 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		BLDG & FIXT (SQUARE FEET)	OFFSITE MOBS (MOB SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
		1.00	1.01	2.00	4.00	5A.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	104,783				1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	0	100			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			328,324		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		0	16,763,450		4.00
5.01	01140	BUSINESS OFFICE	1,330	0	108	-8,116	5.01
5.02	00550	DATA PROCESSING	1,553	0	8,044	0	5.02
5.03	00570	ADMINISTRATIVE	820	0	101	0	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	364	0	112	124,875	5.04
5.05	00590	OTHER A&G	19,467	0	8,906	560,665	5.05
7.00	00700	OPERATION OF PLANT	4,483	0	16,174	261,060	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	474	0	0	16,081	8.00
9.00	00900	HOUSEKEEPING	1,094	0	937	449,439	9.00
10.00	01000	DIETARY	2,721	0	8,981	111,405	10.00
11.00	01100	CAFETERIA	1,074	0	0	229,488	11.00
13.00	01300	NURSING ADMINISTRATION	355	0	0	259,929	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	887	0	64	0	16.00
17.00	01700	SOCIAL SERVICE	299	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,277	0	47,300	1,828,685	30.00
31.00	03100	INTENSIVE CARE UNIT	2,314	0	916	188,029	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,371	0	77,878	452,022	50.00
51.00	05100	RECOVERY ROOM	4,904	0	0	107,656	51.00
53.00	05300	ANESTHESIOLOGY	129	0	12,108	1,065	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,351	0	23,740	394,580	54.00
54.01	05401	ULTRASOUND	210	0	0	8,923	54.01
54.02	05402	MAMMOGRAPHY	146	0	7,458	122,846	54.02
56.00	05600	RADIOISOTOPE	687	0	0	3,653	56.00
57.00	05700	CT SCAN	463	0	20,114	183,646	57.00
58.00	05800	MRI	1,037	0	0	105,378	58.00
60.00	06000	LABORATORY	1,792	0	28,083	755,126	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	106	0	1,910	0	63.00
64.00	06400	INTRAVENOUS THERAPY	4,492	0	522	326,156	64.00
65.00	06500	RESPIRATORY THERAPY	1,395	0	10,937	486,029	65.00
65.01	06501	SLEEP LAB	239	0	2,669	69,423	65.01
66.00	06600	PHYSICAL THERAPY	2,094	0	1,801	651,268	66.00
67.00	06700	OCCUPATIONAL THERAPY	273	0	0	130,228	67.00
68.00	06800	SPEECH PATHOLOGY	101	0	0	41,167	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	117	0	0	4,983	69.01
69.02	06902	CARDIOLOGY	102	0	7,832	0	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,797	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	791	0	18,295	240,510	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	218	0	0	73,110	76.00
76.97	07697	CARDIAC REHABILITATION	531	0	2,130	63,985	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,391	0	5,176	3,388,168	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,948	0	15,566	1,514,147	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							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	96,338	0	327,862	13,153,725	-8,116
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	242	0	0	0	-57,337
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,260	100	0	15	0
192.01	19201	PHYSICIAN OFFICE PRIOR TO RHC CERT	4,825	0	0	3,605,219	0
194.00	07950	OTHER NRCC	0	0	462	4,491	5,098
194.01	07951	MARKETING	59	0	0	0	-214
194.02	07952	FOUNDATION	59	0	0	0	-43,062

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1310

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

Worksheet B-1

Date/Time Prepared:
2/25/2024 7:10 pm

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			BLDG & FIXT (SQUARE FEET)	OFFSITE MOBS (MOB SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
			1.00	1.01	2.00	4.00	5A.01	
194.03	07953	RESEARCH	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	341,170	0	754,312	4,164,601		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.255967	0.000000	2.297462	0.248433		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				459		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000027		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: 14-1310

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

Worksheet B-1

Date/Time Prepared:
2/25/2024 7:10 pm

Cost Center Description			BUSINESS OFFICE (ACCUM. COST)	DATA PROCESSING (MACHINE HOURS)	Reconciliation	ADMINISTRATIVE (ACCUM. COST)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
			5.01	5.02	5A.03	5.03	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE	35,268,084					5.01
5.02	00550	DATA PROCESSING	1,067,331	872				5.02
5.03	00570	ADMINITTING	2,902	0	-2,903	30,021,442		5.03
5.04	00560	PURCHASING RECEIVING AND STORES	409,145	2	0	411,688	938,984	5.04
5.05	00590	OTHER A&G	4,941,695	128	0	5,099,540	7,806	5.05
7.00	00700	OPERATION OF PLANT	1,470,202	0	0	1,470,540	3,198	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	103,282	0	0	103,306	0	8.00
9.00	00900	HOUSEKEEPING	736,124	3	0	739,966	67,963	9.00
10.00	01000	DIETARY	218,725	0	0	218,775	5,490	10.00
11.00	01100	CAFETERIA	317,218	0	0	317,291	11,477	11.00
13.00	01300	NURSING ADMINISTRATION	686,057	10	0	698,458	136	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	59,687	0	0	59,701	384	16.00
17.00	01700	SOCIAL SERVICE	237,900	0	0	237,955	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,691,818	172	0	2,903,014	81,233	30.00
31.00	03100	INTENSIVE CARE UNIT	279,701	0	0	279,765	15,041	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,142,118	0	0	1,142,381	167,160	50.00
51.00	05100	RECOVERY ROOM	171,683	2	0	174,171	15,049	51.00
53.00	05300	ANESTHESIOLOGY	48,365	25	0	78,983	15,471	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	964,941	67	0	1,047,190	10,731	54.00
54.01	05401	ULTRASOUND	340,446	0	0	340,524	17,437	54.01
54.02	05402	MAMMOGRAPHY	178,308	0	0	178,349	1,085	54.02
56.00	05600	RADIOISOTOPE	186,242	0	0	186,285	1,569	56.00
57.00	05700	CT SCAN	336,740	0	0	336,817	46,834	57.00
58.00	05800	MRI	152,489	0	0	152,524	12,295	58.00
60.00	06000	LABORATORY	1,819,636	113	0	1,958,399	89,008	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	55,995	0	0	56,008	0	63.00
64.00	06400	INTRAVENOUS THERAPY	458,829	125	0	611,971	28,950	64.00
65.00	06500	RESPIRATORY THERAPY	688,742	0	0	688,900	50,886	65.00
65.01	06501	SLEEP LAB	103,680	0	0	103,704	8,538	65.01
66.00	06600	PHYSICAL THERAPY	872,279	11	0	885,947	7,813	66.00
67.00	06700	OCCUPATIONAL THERAPY	177,630	0	0	177,671	904	67.00
68.00	06800	SPEECH PATHOLOGY	55,259	0	0	55,272	884	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	6,897	0	0	6,899	303	69.01
69.02	06902	CARDIOLOGY	21,368	0	0	21,373	2,601	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	51,778	0	0	51,790	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	189,267	0	0	189,311	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,393,100	0	0	1,393,420	14,429	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	92,402	0	0	92,423	93	76.00
76.97	07697	CARDIAC REHABILITATION	85,695	0	0	85,715	911	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,006,228	191	-5,241,220	0	36,003	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,458,520	23	0	2,487,244	148,748	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,280,424	872	-5,244,123	25,043,270	870,430	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	-57,337	0	55,706	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,633	0	-10,635	0	0	192.00
192.01	19201	PHYSICIAN OFFICE PRIOR TO RHC CERT	4,977,027	0	0	4,978,172	12,825	192.01
194.00	07950	OTHER NRCC	0	0	5,098	0	0	194.00
194.01	07951	MARKETING	0	0	-214	0	22	194.01
194.02	07952	FOUNDATION	0	0	-43,062	0	1	194.02
194.03	07953	RESEARCH	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1310

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

Worksheet B-1

Date/Time Prepared:
2/25/2024 7:10 pm

Cost Center Description		BUSINESS OFFICE (ACCUM. COST)	DATA PROCESSING (MACHINE HOURS)	Reconciliation	ADMITTING (ACCUM. COST)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
		5.01	5.02	5A.03	5.03	5.04	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	8,116	1,067,576		2,903	411,728	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000230	1,224.284404		0.000097	0.438482	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	4,578	23,677		2,902	1,592	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000130	27.152523		0.000097	0.001695	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: 14-1310

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

Worksheet B-1

Date/Time Prepared:
2/25/2024 7:10 pm

Cost Center Description			Reconciliation	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5A.05	5.05	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMINISTRATIVE						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G	-5,103,448	30,273,365				5.05
7.00	00700	OPERATION OF PLANT	0	1,472,085	76,625			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	103,316	474	85,906		8.00
9.00	00900	HOUSEKEEPING	0	769,839	1,094	0	2,183	9.00
10.00	01000	DIETARY	0	221,203	2,721	0	0	10.00
11.00	01100	CAFETERIA	0	322,354	1,074	0	24	11.00
13.00	01300	NURSING ADMINISTRATION	0	698,586	355	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	59,875	887	0	27	16.00
17.00	01700	SOCIAL SERVICE	0	237,978	299	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,938,915	15,277	22,028	538	30.00
31.00	03100	INTENSIVE CARE UNIT	0	286,387	2,314	747	62	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,215,789	4,371	3,561	137	50.00
51.00	05100	RECOVERY ROOM	0	180,787	4,904	435	154	51.00
53.00	05300	ANESTHESIOLOGY	0	85,775	129	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,051,997	3,351	2,339	93	54.00
54.01	05401	ULTRASOUND	0	348,203	210	1,400	6	54.01
54.02	05402	MAMMOGRAPHY	0	178,842	146	1,127	4	54.02
56.00	05600	RADIOISOTOPE	0	186,991	687	776	19	56.00
57.00	05700	CT SCAN	0	357,386	463	11,254	13	57.00
58.00	05800	MRI	0	157,930	1,037	2,770	29	58.00
60.00	06000	LABORATORY	0	1,997,617	1,792	0	95	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	56,013	106	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	624,724	4,492	0	91	64.00
65.00	06500	RESPIRATORY THERAPY	0	711,280	1,395	932	40	65.00
65.01	06501	SLEEP LAB	0	107,458	239	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	889,459	2,094	5,043	175	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	178,084	273	1,029	23	67.00
68.00	06800	SPEECH PATHOLOGY	0	55,665	101	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	0	7,033	117	0	0	69.01
69.02	06902	CARDIOLOGY	0	22,515	102	0	0	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	51,795	2,797	0	7	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	189,329	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,399,882	791	0	14	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	92,473	218	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	86,122	531	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	5,257,007	8,391	661	234	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,552,708	4,948	31,804	307	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,103,448	25,153,402	68,180	85,906	2,092	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	81,763	242	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,635	3,260	0	91	192.00
192.01	19201	PHYSICIAN OFFICE PRIOR TO RHC CERT	0	4,984,279	4,825	0	0	192.01
194.00	07950	OTHER NRCC	5,098	0	0	0	0	194.00
194.01	07951	MARKETING	0	224	59	0	0	194.01
194.02	07952	FOUNDATION	0	43,062	59	0	0	194.02
194.03	07953	RESEARCH	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1310

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

Worksheet B-1

Date/Time Prepared:
2/25/2024 7:10 pm

Cost Center Description			Reconciliation	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5A.05	5.05	7.00	8.00	9.00	
202.00		Cost to be allocated (per Wkst. B, Part I)		5,103,448	1,720,248	131,374	924,179	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.168579	22.450219	1.529276	423.352726	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		88,475	56,405	2,217	9,146	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.002923	0.736117	0.025807	4.189647	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: 14-1310

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

Worksheet B-1

Date/Time Prepared:
2/25/2024 7:10 pm

Cost Center Description			DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
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	9,478					10.00
11.00	01100	CAFETERIA	0	14,690				11.00
13.00	01300	NURSING ADMINISTRATION	0	214	102,349			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	480		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	180	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,629	2,305	47,947	96	180	30.00
31.00	03100	INTENSIVE CARE UNIT	102	140	2,912	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	500	10,401	0	0	50.00
51.00	05100	RECOVERY ROOM	95	133	2,761	80	0	51.00
53.00	05300	ANESTHESIOLOGY	0	71	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44	545	0	8	0	54.00
54.01	05401	ULTRASOUND	0	8	0	5	0	54.01
54.02	05402	MAMMOGRAPHY	0	157	0	4	0	54.02
56.00	05600	RADIOISOTOPE	0	3	0	3	0	56.00
57.00	05700	CT SCAN	0	244	0	38	0	57.00
58.00	05800	MRI	0	116	0	9	0	58.00
60.00	06000	LABORATORY	0	1,138	0	56	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	430	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	594	0	0	0	65.00
65.01	06501	SLEEP LAB	0	104	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	676	0	51	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	147	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	54	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	0	4	91	0	0	69.01
69.02	06902	CARDIOLOGY	0	0	0	0	0	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	246	5,107	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0	72	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	100	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	2,689	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	608	1,593	33,130	130	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,478	12,283	102,349	480	180	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PHYSICIAN OFFICE PRIOR TO RHC CERT	0	2,402	0	0	0	192.01
194.00	07950	OTHER NRCC	0	5	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	RESEARCH	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1310

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

Worksheet B-1

Date/Time Prepared:
2/25/2024 7:10 pm

Cost Center Description		DI ETARY (MEALS SERVED)	CAFETERIA (FTE' S)	NURSING ADMINI STRATIO N (DI RECT NRSING HRS)	MEDI CAL RECORDS & LI BRARY (TIME SPENT)	SOCI AL SERVI CE (TIME SPENT)	
		10.00	11.00	13.00	16.00	17.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	319,580	410,968	830,310	101,313	284,809	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	33.718084	27.976038	8.112537	211.068750	1,582.272222	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	32,204	5,428	3,974	3,991	1,944	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.397763	0.369503	0.038828	8.314583	10.800000	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: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet C
Part I
Date/Time Prepared:
2/25/2024 7:10 pm

			Title XVIII		Hospital		Cost		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance		Total Costs	
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,088,256		5,088,256	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	444,986		444,986	0	0	31.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,680,686		1,680,686	0	0	50.00	
51.00	05100	RECOVERY ROOM	433,430		433,430	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	105,117		105,117	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,365,942		1,365,942	0	0	54.00	
54.01	05401	ULTRASOUND	417,578		417,578	0	0	54.01	
54.02	05402	MAMMOGRAPHY	220,921		220,921	0	0	54.02	
56.00	05600	RADIOISOTOPE	243,885		243,885	0	0	56.00	
57.00	05700	CT SCAN	465,589		465,589	0	0	57.00	
58.00	05800	MRI	229,493		229,493	0	0	58.00	
60.00	06000	LABORATORY	2,458,480		2,458,480	0	0	60.00	
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	67,836		67,836	0	0	63.00	
64.00	06400	INTRAVENOUS THERAPY	881,440		881,440	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	897,482	0	897,482	0	0	65.00	
65.01	06501	SLEEP LAB	133,849	0	133,849	0	0	65.01	
66.00	06600	PHYSICAL THERAPY	1,197,890	0	1,197,890	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	229,657	0	229,657	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	68,827	0	68,827	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00	
69.01	06901	ECHOCARDIOGRAPHY	11,696		11,696	0	0	69.01	
69.02	06902	CARDIOLOGY	28,601		28,601	0	0	69.02	
69.03	06903	PULMONARY REHAB	0		0	0	0	69.03	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	126,283		126,283	0	0	71.00	
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	221,246		221,246	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,707,871		1,707,871	0	0	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00	
76.00	03020	CANCER CARE CENTER	114,970		114,970	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	115,359		115,359	0	0	76.97	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00	
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,506,901		6,506,901	0	0	88.00	
90.00	09000	CLINIC	0		0	0	0	90.00	
91.00	09100	EMERGENCY	3,634,004		3,634,004	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	997,403		997,403		0	92.00	
	OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	30,095,678	0	30,095,678	0	0	200.00	
201.00		Less Observation Beds	997,403		997,403		0	201.00	
202.00		Total (see instructions)	29,098,275	0	29,098,275	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet C
Part I
Date/Time Prepared:
2/25/2024 7:10 pm

			Title XVIII			Hospital		Cost	
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
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,897,049		2,897,049			30.00	
31.00	03100	INTENSIVE CARE UNIT	143,548		143,548			31.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	105,166	2,629,987	2,735,153	0.614476	0.000000	50.00	
51.00	05100	RECOVERY ROOM	9,658	535,607	545,265	0.794898	0.000000	51.00	
53.00	05300	ANESTHESIOLOGY	80,667	1,443,565	1,524,232	0.068964	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	159,950	3,615,911	3,775,861	0.361756	0.000000	54.00	
54.01	05401	ULTRASOUND	80,726	2,499,850	2,580,576	0.161816	0.000000	54.01	
54.02	05402	MAMMOGRAPHY	3,937	1,501,245	1,505,182	0.146774	0.000000	54.02	
56.00	05600	RADIOISOTOPE	30,428	1,223,229	1,253,657	0.194539	0.000000	56.00	
57.00	05700	CT SCAN	689,720	16,021,606	16,711,326	0.027861	0.000000	57.00	
58.00	05800	MRI	122,119	4,252,885	4,375,004	0.052455	0.000000	58.00	
60.00	06000	LABORATORY	1,698,352	17,859,536	19,557,888	0.125703	0.000000	60.00	
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	60,830	86,577	147,407	0.460195	0.000000	63.00	
64.00	06400	INTRAVENOUS THERAPY	418	926,147	926,565	0.951299	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	1,061,967	701,936	1,763,903	0.508805	0.000000	65.00	
65.01	06501	SLEEP LAB	0	667,249	667,249	0.200598	0.000000	65.01	
66.00	06600	PHYSICAL THERAPY	267,324	3,644,291	3,911,615	0.306239	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	75,274	721,459	796,733	0.288248	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	9,522	130,901	140,423	0.490141	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00	
69.01	06901	ECHOCARDIOGRAPHY	251,882	2,057,068	2,308,950	0.005066	0.000000	69.01	
69.02	06902	CARDIOLOGY	87,864	1,636,642	1,724,506	0.016585	0.000000	69.02	
69.03	06903	PULMONARY REHAB	0	0	0	0.000000	0.000000	69.03	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	362	77,500	77,862	1.621882	0.000000	71.00	
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	2,242,177	2,242,177	0.098675	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,920,716	6,250,247	8,170,963	0.209017	0.000000	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00	
76.00	03020	CANCER CARE CENTER	0	5,350	5,350	21.489720	0.000000	76.00	
76.97	07697	CARDIAC REHABILITATION	0	229,352	229,352	0.502978	0.000000	76.97	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00	
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	7,655,278	7,655,278			88.00	
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00	
91.00	09100	EMERGENCY	346,889	10,277,221	10,624,110	0.342053	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	121,993	816,999	938,992	1.062206	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	10,226,361	89,709,815	99,936,176			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	10,226,361	89,709,815	99,936,176			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet C
Part I
Date/Time Prepared:
2/25/2024 7:10 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401 ULTRASOUND	0.000000			54.01
54.02	05402 MAMMOGRAPHY	0.000000			54.02
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MRI	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000			63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
65.01	06501 SLEEP LAB	0.000000			65.01
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
69.01	06901 ECHOCARDIOGRAPHY	0.000000			69.01
69.02	06902 CARDIOLOGY	0.000000			69.02
69.03	06903 PULMONARY REHAB	0.000000			69.03
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000			75.00
76.00	03020 CANCER CARE CENTER	0.000000			76.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000			77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000			78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
102.00	10200 OPIOID TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet D
Part II
Date/Time Prepared:
2/25/2024 7:10 pm

Cost Center Description		Capital Related Cost (from Wkst. C, Part I, 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	201,738	2,735,153	0.073757	6,969	514	50.00
51.00	05100 RECOVERY ROOM	22,027	545,265	0.040397	774	31	51.00
53.00	05300 ANESTHESIOLOGY	29,329	1,524,232	0.019242	6,354	122	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	73,938	3,775,861	0.019582	52,034	1,019	54.00
54.01	05401 ULTRASOUND	2,070	2,580,576	0.000802	28,608	23	54.01
54.02	05402 MAMMOGRAPHY	18,421	1,505,182	0.012238	3,063	37	54.02
56.00	05600 RADIOISOTOPE	3,461	1,253,657	0.002761	6,405	18	56.00
57.00	05700 CT SCAN	50,016	16,711,326	0.002993	171,099	512	57.00
58.00	05800 MRI	4,970	4,375,004	0.001136	56,331	64	58.00
60.00	06000 LABORATORY	82,463	19,557,888	0.004216	582,699	2,457	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	4,987	147,407	0.033832	41,240	1,395	63.00
64.00	06400 INTRAVENOUS THERAPY	25,069	926,565	0.027056	340	9	64.00
65.00	06500 RESPIRATORY THERAPY	33,442	1,763,903	0.018959	386,080	7,320	65.00
65.01	06501 SLEEP LAB	7,477	667,249	0.011206	0	0	65.01
66.00	06600 PHYSICAL THERAPY	17,163	3,911,615	0.004388	48,690	214	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,834	796,733	0.002302	18,127	42	67.00
68.00	06800 SPEECH PATHOLOGY	600	140,423	0.004273	5,702	24	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901 ECHOCARDIOGRAPHY	496	2,308,950	0.000215	150,372	32	69.01
69.02	06902 CARDIOLOGY	18,476	1,724,506	0.010714	30,224	324	69.02
69.03	06903 PULMONARY REHAB	0	0	0.000000	0	0	69.03
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11,358	77,862	0.145873	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	596	2,242,177	0.000266	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	49,975	8,170,963	0.006116	566,115	3,462	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.00	03020 CANCER CARE CENTER	1,190	5,350	0.222430	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	7,326	229,352	0.031942	0	0	76.97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	68,715	7,655,278	0.008976	0	0	88.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	71,586	10,624,110	0.006738	8,962	60	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	43,386	938,992	0.046205	9,990	462	92.00
200.00	Total (lines 50 through 199)	852,109	96,895,579		2,180,178	18,141	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1310		Period: From 10/01/2022 To 09/30/2023		Worksheet D Part IV Date/Time Prepared: 2/25/2024 7:10 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
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	05401	ULTRASOUND		0	0	0	0	0	54.01
54.02	05402	MAMMOGRAPHY		0	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
65.01	06501	SLEEP LAB		0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY		0	0	0	0	0	69.01
69.02	06902	CARDIOLOGY		0	0	0	0	0	69.02
69.03	06903	PULMONARY REHAB		0	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER		0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0	88.00
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	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: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet D
Part IV
Date/Time Prepared:
2/25/2024 7:10 pm

			Title XVIII		Hospital	Cost		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,735,153	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	545,265	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,524,232	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,775,861	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	2,580,576	0.000000	54.01
54.02	05402	MAMMOGRAPHY	0	0	0	1,505,182	0.000000	54.02
56.00	05600	RADIOISOTOPE	0	0	0	1,253,657	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	16,711,326	0.000000	57.00
58.00	05800	MRI	0	0	0	4,375,004	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	19,557,888	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	147,407	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	926,565	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,763,903	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	667,249	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	3,911,615	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	796,733	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	140,423	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	06901	ECHOCARDIOGRAPHY	0	0	0	2,308,950	0.000000	69.01
69.02	06902	CARDIOLOGY	0	0	0	1,724,506	0.000000	69.02
69.03	06903	PULMONARY REHAB	0	0	0	0	0.000000	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	77,862	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	2,242,177	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,170,963	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.00	03020	CANCER CARE CENTER	0	0	0	5,350	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	229,352	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	7,655,278	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	10,624,110	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	938,992	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	96,895,579		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet D
Part IV
Date/Time Prepared:
2/25/2024 7:10 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	6,969	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	774	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	6,354	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	52,034	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	28,608	0	0	0	54.01
54.02	05402	MAMMOGRAPHY	0.000000	3,063	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.000000	6,405	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	171,099	0	0	0	57.00
58.00	05800	MRI	0.000000	56,331	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	582,699	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	41,240	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	340	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	386,080	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	48,690	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	18,127	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	5,702	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	0.000000	150,372	0	0	0	69.01
69.02	06902	CARDIOLOGY	0.000000	30,224	0	0	0	69.02
69.03	06903	PULMONARY REHAB	0.000000	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	566,115	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	8,962	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	9,990	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,180,178	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet D
Part V
Date/Time Prepared:
2/25/2024 7:10 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	PPS Services (see inst.)	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.614476	0	490,582	0	0	50.00
51.00	05100	RECOVERY ROOM	0.794898	0	94,478	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.068964	0	233,935	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.361756	0	1,045,623	0	0	54.00
54.01	05401	ULTRASOUND	0.161816	0	699,720	0	0	54.01
54.02	05402	MAMMOGRAPHY	0.146774	0	276,394	0	0	54.02
56.00	05600	RADIOISOTOPE	0.194539	0	497,005	0	0	56.00
57.00	05700	CT SCAN	0.027861	0	5,697,219	0	0	57.00
58.00	05800	MRI	0.052455	0	1,338,336	0	0	58.00
60.00	06000	LABORATORY	0.125703	0	5,795,982	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.460195	0	47,296	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.951299	0	333,570	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.508805	0	228,676	0	0	65.00
65.01	06501	SLEEP LAB	0.200598	0	195,059	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.306239	0	1,259,537	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.288248	0	77,701	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.490141	0	21,764	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	0.005066	0	903,444	0	0	69.01
69.02	06902	CARDIOLOGY	0.016585	0	593,267	0	0	69.02
69.03	06903	PULMONARY REHAB	0.000000	0	0	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.621882	0	8,876	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.098675	0	368,468	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.209017	0	2,709,196	4,808	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03020	CANCER CARE CENTER	21.489720	0	1,670	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.502978	0	119,257	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.342053	0	2,892,604	328	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.062206	0	363,870	0	0	92.00
200.00		Subtotal (see instructions)		0	26,293,529	5,136	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	26,293,529	5,136	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1310		Period: From 10/01/2022 To 09/30/2023		Worksheet D Part V Date/Time Prepared: 2/25/2024 7:10 pm	
				Title XVIII		Hospital		Cost	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	301,451	0					50.00
51.00	05100	RECOVERY ROOM	75,100	0					51.00
53.00	05300	ANESTHESIOLOGY	16,133	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	378,260	0					54.00
54.01	05401	ULTRASOUND	113,226	0					54.01
54.02	05402	MAMMOGRAPHY	40,567	0					54.02
56.00	05600	RADIOISOTOPE	96,687	0					56.00
57.00	05700	CT SCAN	158,730	0					57.00
58.00	05800	MRI	70,202	0					58.00
60.00	06000	LABORATORY	728,572	0					60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	21,765	0					63.00
64.00	06400	INTRAVENOUS THERAPY	317,325	0					64.00
65.00	06500	RESPIRATORY THERAPY	116,351	0					65.00
65.01	06501	SLEEP LAB	39,128	0					65.01
66.00	06600	PHYSICAL THERAPY	385,719	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	22,397	0					67.00
68.00	06800	SPEECH PATHOLOGY	10,667	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
69.01	06901	ECHOCARDIOGRAPHY	4,577	0					69.01
69.02	06902	CARDIOLOGY	9,839	0					69.02
69.03	06903	PULMONARY REHAB	0	0					69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,396	0					71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	36,359	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	566,268	1,005					73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0					75.00
76.00	03020	CANCER CARE CENTER	35,888	0					76.00
76.97	07697	CARDIAC REHABILITATION	59,984	0					76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0					77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0					78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	989,424	112					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	386,505	0					92.00
200.00		Subtotal (see instructions)	4,995,520	1,117					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	4,995,520	1,117					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1310	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/25/2024 7:10 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)			3,106	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,044	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)			1,465	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			222	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)			667	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			43	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)			130	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			753	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)			214	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)			388	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			201.56	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			208.70	20.00
21.00	Total general inpatient routine service cost (see instructions)			5,088,256	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)			8,667	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)			27,131	25.00
26.00	Total swing-bed cost (see instructions)			1,567,207	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,521,049	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			3,521,049	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)			1,722.62	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,297,133	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,297,133	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1310

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

Worksheet D-1

Date/Time Prepared:
2/25/2024 7:10 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	444,986	62	7,177.19	25	179,430
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)					483,391
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					1,959,954
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
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
55.01	Permanent adjustment amount per discharge					0.00
55.02	Adjustment amount per discharge (contractor use only)					0.00
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
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
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
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)					368,641
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					668,377
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					1,037,018
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00	Program routine service cost (line 9 x line 71)					
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00	Per diem capital-related costs (line 75 ÷ line 2)					
77.00	Program capital-related costs (line 9 x line 76)					
78.00	Inpatient routine service cost (line 74 minus line 77)					
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00	Inpatient routine service cost per diem limitation					
82.00	Inpatient routine service cost limitation (line 9 x line 81)					
83.00	Reasonable inpatient routine service costs (see instructions)					
84.00	Program inpatient ancillary services (see instructions)					
85.00	Utilization review - physician compensation (see instructions)					
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					579
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,722.63

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-1310	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/25/2024 7:10 pm	
				Title XVIII	Hospital	Cost	
Cost Center Description						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					997,403	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	221,334	5,088,256	0.043499	997,403	43,386	90.00
91.00	Nursing Program cost	0	5,088,256	0.000000	997,403	0	91.00
92.00	Allied health cost	0	5,088,256	0.000000	997,403	0	92.00
93.00	All other Medical Education	0	5,088,256	0.000000	997,403	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1310	Period: From 10/01/2022 To 09/30/2023	Worksheet D-3 Date/Time Prepared: 2/25/2024 7:10 pm	
Cost Center Description			Title XVIII	Hospital	Cost	
			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		881,944		30.00
31.00	03100	INTENSIVE CARE UNIT		57,786		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.614476	6,969	4,282	50.00
51.00	05100	RECOVERY ROOM	0.794898	774	615	51.00
53.00	05300	ANESTHESIOLOGY	0.068964	6,354	438	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.361756	52,034	18,824	54.00
54.01	05401	ULTRASOUND	0.161816	28,608	4,629	54.01
54.02	05402	MAMMOGRAPHY	0.146774	3,063	450	54.02
56.00	05600	RADIOISOTOPE	0.194539	6,405	1,246	56.00
57.00	05700	CT SCAN	0.027861	171,099	4,767	57.00
58.00	05800	MRI	0.052455	56,331	2,955	58.00
60.00	06000	LABORATORY	0.125703	582,699	73,247	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.460195	41,240	18,978	63.00
64.00	06400	INTRAVENOUS THERAPY	0.951299	340	323	64.00
65.00	06500	RESPIRATORY THERAPY	0.508805	386,080	196,439	65.00
65.01	06501	SLEEP LAB	0.200598	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.306239	48,690	14,911	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.288248	18,127	5,225	67.00
68.00	06800	SPEECH PATHOLOGY	0.490141	5,702	2,795	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	ECHOCARDIOGRAPHY	0.005066	150,372	762	69.01
69.02	06902	CARDIOLOGY	0.016585	30,224	501	69.02
69.03	06903	PULMONARY REHAB	0.000000	0	0	69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.621882	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.098675	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.209017	566,115	118,328	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.00	03020	CANCER CARE CENTER	21.489720	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.502978	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.342053	8,962	3,065	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.062206	9,990	10,611	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,180,178	483,391	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,180,178		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1310	Period: From 10/01/2022 To 09/30/2023	Worksheet D-3
			Component CCN: 14-Z310		Date/Time Prepared: 2/25/2024 7:10 pm
			Title XVIII	Swing Beds - SNF	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.614476	2,935	1,803 50.00
51.00	05100	RECOVERY ROOM	0.794898	0	0 51.00
53.00	05300	ANESTHESIOLOGY	0.068964	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.361756	5,011	1,813 54.00
54.01	05401	ULTRASOUND	0.161816	3,709	600 54.01
54.02	05402	MAMMOGRAPHY	0.146774	295	43 54.02
56.00	05600	RADIOISOTOPE	0.194539	6,405	1,246 56.00
57.00	05700	CT SCAN	0.027861	23,094	643 57.00
58.00	05800	MRI	0.052455	8,690	456 58.00
60.00	06000	LABORATORY	0.125703	137,847	17,328 60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.460195	19,227	8,848 63.00
64.00	06400	INTRAVENOUS THERAPY	0.951299	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.508805	125,624	63,918 65.00
65.01	06501	SLEEP LAB	0.200598	0	0 65.01
66.00	06600	PHYSICAL THERAPY	0.306239	109,853	33,641 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.288248	23,425	6,752 67.00
68.00	06800	SPEECH PATHOLOGY	0.490141	1,574	771 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0 69.00
69.01	06901	ECHOCARDIOGRAPHY	0.005066	4,238	21 69.01
69.02	06902	CARDIOLOGY	0.016585	3,485	58 69.02
69.03	06903	PULMONARY REHAB	0.000000	0	0 69.03
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.621882	0	0 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.098675	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.209017	307,382	64,248 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0 75.00
76.00	03020	CANCER CARE CENTER	21.489720	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0.502978	0	0 76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0 77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0 78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
90.00	09000	CLINIC	0.000000	0	0 90.00
91.00	09100	EMERGENCY	0.342053	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.062206	1,470	1,561 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		784,264	203,750 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		784,264	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1310	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/25/2024 7:10 pm
		Title XVIII	Hospital	Cost
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,996,637	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		0	2.00
3.00	OPPTS 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)		4,996,637	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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		5,046,603	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)		45,975	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,968,492	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,032,136	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
28.50	REH facility payment amount			28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)		1,032,136	30.00
31.00	Primary payer payments		19	31.00
32.00	Subtotal (line 30 minus line 31)		1,032,117	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)		311,321	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		202,359	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		284,071	36.00
37.00	Subtotal (see instructions)		1,234,476	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)		1,234,476	40.00
40.01	Sequestration adjustment (see instructions)		24,690	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		2,473,162	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		-1,263,376	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		46,550	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

Health Financial Systems		MENDOTA COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1310	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/25/2024 7:10 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: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet E-1
Part I
Date/Time Prepared:
2/25/2024 7:10 pm

		Title XVIII		Hospital	Cost	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,611,348		2,788,019	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	05/16/2023	80,034		0	3.01
3.02		09/12/2023	13,633		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	05/16/2023	244,997	3.50
3.51			0	09/12/2023	69,860	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)		93,667		-314,857	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)		1,705,015		2,473,162	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		49,435		1,263,376	6.02
7.00	Total Medicare program liability (see instructions)		1,655,580		1,209,786	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: 14-1310

Period:

Worksheet E-1

Component CCN: 14-Z310

From 10/01/2022
To 09/30/2023Part I
Date/Time Prepared:
2/25/2024 7:10 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		1,192,606		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	05/16/2023	41,988		0	3.01
3.02		09/12/2023	11,189		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)		53,177		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)		1,245,783		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		30,018		0	6.02
7.00	Total Medicare program liability (see instructions)		1,215,765		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: 14-1310	Period: From 10/01/2022 To 09/30/2023	Worksheet E-1 Part II Date/Time Prepared: 2/25/2024 7:10 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: 14-1310	Period: From 10/01/2022 To 09/30/2023	Worksheet E-2	
		Component CCN: 14-Z310		Date/Time Prepared: 2/25/2024 7:10 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)		1,047,388	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)		205,788	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		602	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)		1,253,176	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,253,176	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)		1,253,176	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		15,329	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,237,847	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)		4,200	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		2,730	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		4,200	0	18.00
19.00	Total (see instructions)		1,240,577	0	19.00
19.01	Sequestration adjustment (see instructions)		24,812	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		1,245,783	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)		-30,018	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison 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: 14-1310	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part V Date/Time Prepared: 2/25/2024 7:10 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			1,959,954 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)			1,959,954 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,979,554 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)			1,979,554 19.00
20.00	Deductibles (exclude professional component)			303,367 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			1,676,187 22.00
23.00	Coinurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			1,676,187 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			20,277 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			13,180 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			16,515 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,689,367 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)			1,689,367 30.00
30.01	Sequestration adjustment (see instructions)			33,787 30.01
30.02	Demonstration payment adjustment amount after sequestration			0 30.02
30.03	Sequestration adjustment-PARHM			0 30.03
31.00	Interim payments			1,705,015 31.00
31.01	Interim payments-PARHM			0 31.01
32.00	Tentative settlement (for contractor use only)			0 32.00
32.01	Tentative settlement-PARHM (for contractor use only)			0 32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)			-49,435 33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)			0 33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			1,860 34.00

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

Provider CCN: 14-1310

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

Worksheet G

Date/Time Prepared:
2/25/2024 7:10 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	-10,928,029	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	14,128,042	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,062,869	0	0	0	6.00
7.00	Inventory	512,016	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	157,802	0	0	0	9.00
10.00	Due from other funds	151,896	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	-4,041,142	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,427,000	0	0	0	12.00
13.00	Land improvements	2,117,935	0	0	0	13.00
14.00	Accumulated depreciation	-1,235,446	0	0	0	14.00
15.00	Buildings	19,184,923	0	0	0	15.00
16.00	Accumulated depreciation	-7,507,014	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	14,975,090	0	0	0	23.00
24.00	Accumulated depreciation	-12,106,700	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	228,029	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	18,083,817	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	241,309	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	12,749,334	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	12,990,643	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	27,033,318	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	660,633	0	0	0	37.00
38.00	Salaries, wages, and fees payable	150,681	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	2,631,567	0	0	0	43.00
44.00	Other current liabilities	64,460	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,507,341	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	24,538	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	24,538	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,531,879	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	23,501,439				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)	23,501,439	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	27,033,318	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1310

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

Worksheet G-1

Date/Time Prepared:
2/25/2024 7:10 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		19,068,672		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,332,153				2.00
3.00	Total (sum of line 1 and line 2)		23,400,825		0		3.00
4.00	TEMP RESTRICTED FUNDS	100,614		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)		100,614		0		10.00
11.00	Subtotal (line 3 plus line 10)		23,501,439		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)		23,501,439		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	TEMP RESTRICTED FUNDS		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: 14-1310

Period:
From 10/01/2022
To 09/30/2023Worksheet G-2
Parts I & II
Date/Time Prepared:
2/25/2024 7:10 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,801,501		1,801,501	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	917,083		917,083	5.00
6.00	Swing bed - NF	178,465		178,465	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,897,049		2,897,049	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	143,548		143,548	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)	143,548		143,548	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,040,597		3,040,597	17.00
18.00	Ancillary services	6,716,882	74,156,420	80,873,302	18.00
19.00	Outpatient services	468,882	11,094,220	11,563,102	19.00
20.00	RURAL HEALTH CLINIC	0	7,655,278	7,655,278	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	PROFESSIONAL FEES	340	650,696	651,036	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,226,701	93,556,614	103,783,315	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		37,256,142		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)		37,256,142		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1310

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

Worksheet G-3

Date/Time Prepared:
2/25/2024 7:10 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	103,783,315	1.00
2.00	Less contractual allowances and discounts on patients' accounts	64,175,302	2.00
3.00	Net patient revenues (line 1 minus line 2)	39,608,013	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	37,256,142	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,351,871	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	69,845	6.00
7.00	Income from investments	22,769	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	76,121	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	318,251	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	840	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	60,034	20.00
21.00	Rental of vending machines	624	21.00
22.00	Rental of hospital space	40,310	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,776,700	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	2,365,494	25.00
26.00	Total (line 5 plus line 25)	4,717,365	26.00
27.00	EQUITY TRANSFERS	385,212	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	385,212	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,332,153	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1310

Period:

Worksheet M-1

Component CCN: 14-8535

From 10/01/2022
To 09/30/2023Date/Time Prepared:
2/25/2024 7:10 pm

				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassification s	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	1,272,178	0	1,272,178	-13,481	1,258,697	1.00
2.00	Physician Assistant	110,859	0	110,859	-5,605	105,254	2.00
3.00	Nurse Practitioner	550,241	0	550,241	-1,599	548,642	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,163,009	0	1,163,009	901	1,163,910	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	3,096,287	0	3,096,287	-19,784	3,076,503	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	311,372	311,372	0	311,372	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	8,973	8,973	0	8,973	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	320,345	320,345	0	320,345	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,096,287	320,345	3,416,632	-19,784	3,396,848	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	26,742	26,742	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	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	26,742	26,742	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	72,957	72,957	-35,395	37,562	29.00
30.00	Administrative Costs	283,570	1,413,657	1,697,227	-764,640	932,587	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	283,570	1,486,614	1,770,184	-800,035	970,149	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,379,857	1,806,959	5,186,816	-793,077	4,393,739	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1310

Period:

Worksheet M-1

Component CCN: 14-8535

From 10/01/2022
To 09/30/2023Date/Time Prepared:
2/25/2024 7:10 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	1,258,697		1.00
2.00	Physician Assistant	0	105,254		2.00
3.00	Nurse Practitioner	0	548,642		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	1,163,910		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,076,503		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	311,372		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	8,973		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	320,345		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,396,848		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	26,742		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	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	26,742		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	37,562		29.00
30.00	Administrative Costs	-268,457	664,130		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-268,457	701,692		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-268,457	4,125,282		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1310

Period:

Worksheet M-2

Component CCN: 14-8535

From 10/01/2022

To 09/30/2023

Date/Time Prepared:
2/25/2024 7:10 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	2.80	10,586	4,200	11,760	1.00
2.00	Physician Assistant	0.67	3,096	2,100	1,407	2.00
3.00	Nurse Practitioner	3.86	10,761	2,100	8,106	3.00
4.00	Subtotal (sum of lines 1 through 3)	7.33	24,443		21,273	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	7.33	24,443		24,443	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				3,396,848	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				26,742	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				3,423,590	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.992189	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				701,692	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				2,381,619	15.00
16.00	Total overhead (sum of lines 14 and 15)				3,083,311	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				3,083,311	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				3,059,227	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				6,456,075	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1310 Component CCN: 14-8535	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/25/2024 7:10 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)			6,456,075	1.00	
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			392,591	2.00	
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			6,063,484	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			24,443	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)			24,443	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			248.07	7.00	
			Calculation of Limit (1)			
			Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			268.41	278.61	8.00
9.00	Rate for Program covered visits (see instructions)			248.07	248.07	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			1,604	4,569	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			397,904	1,133,432	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	1,531,336	16.00
16.01	Total program charges (see instructions)(from contractor's records)				1,706,814	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				17,173	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				15,407	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)				1,081,801	16.04
16.05	Total program cost (see instructions)			0	1,097,208	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				163,678	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				304,158	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				1,097,208	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				114,055	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				1,211,263	22.00
23.00	Allowable bad debts (see instructions)				0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)				0	25.50
25.99	Demonstration payment adjustment amount before sequestration				0	25.99
26.00	Net reimbursable amount (see instructions)				1,211,263	26.00
26.01	Sequestration adjustment (see instructions)				24,225	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				1,017,657	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)				169,381	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter I, §115.2				0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1310

Period:

Worksheet M-4

Component CCN: 14-8535

From 10/01/2022
To 09/30/2023Date/Time Prepared:
2/25/2024 7:10 pm

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3,076,503	3,076,503	3,076,503	3,076,503	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002500	0.008499	0.001913	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	7,691	26,147	5,885	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	118,974	47,865	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	126,665	74,012	5,885	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,396,848	3,396,848	3,396,848	3,396,848	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	3,059,227	3,059,227	3,059,227	3,059,227	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.037289	0.021788	0.001732	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	114,076	66,654	5,299	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	240,741	140,666	11,184	0	10.00
11.00	Total number of injections/infusions (from your records)	571	1,941	437	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	421.61	72.47	25.59	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	149	642	184	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)	62,820	46,526	4,709	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)				392,591	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)				114,055	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1310 Component CCN: 14-8535	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/25/2024 7:10 pm	
			RHC I	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,151,682	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			0		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50		05/16/2023	102,673		3.50
3.51		05/16/2023	31,352		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)		-134,025		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,017,657		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		169,381		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		1,187,038		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00 2.00		
8.00	Name of Contractor				8.00