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: 14-1326	Period: From 07/01/2022 To 06/30/2023	Worksheet S Parts I-III Date/Time Prepared: 11/20/2023 2:29 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/20/2023 Time: 2:29 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HAMILTON MEMORIAL HOSPITAL (14-1326) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 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	Justin Epperson		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Justin Epperson			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	285,296	295,212	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	379,635	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		34,455		0	10.00
10.01	RURAL HEALTH CLINIC II	0		2,528		0	10.01
200.00	TOTAL	0	664,931	332,195	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2023 2:29 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 611 SOUTH MARSHALL	PO Box:			1.00
2.00	City: MCLEANSBORO	State: IL	Zip Code: 62859	County: HAMILTON	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	HAMILTON MEMORIAL HOSPITAL	141326	99914	1	05/01/2003	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	HAMILTON MEMORIAL HOSP SWING BED	14Z326	99914		05/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	HAMILTON MEMORIAL FAMILY CLINIC	143477	99914		01/11/2006	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	HAMILTON MEMORIAL FAMILY CLINIC NC	148529	99914		05/06/2013	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2022	06/30/2023	20.00
21.00	Type of Control (see instructions)	11		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2023 2:29 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2023 2:29 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2023 2:29 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2023 2:29 pm

		1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)		
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?	N	68.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2023 2:29 pm

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2023 2:29 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	182,959	0	0	118.01

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

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1326	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/20/2023 2:29 pm

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	Y	Y	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/20/2023 2:29 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/26/2023	Y	10/26/2023	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/20/2023 2:29 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		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.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			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.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4300	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1326	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part II Date/Time Prepared: 11/20/2023 2:29 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SIGNING 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: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2023 2:29 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	39,960.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	39,960.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	39,960.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2023 2:29 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	676	0	932			1.00
2.00	HMO and other (see instructions)	0	43				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,665	0	1,884			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	92			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,341	0	2,908			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)	2,341	0	2,908	0.00	113.57	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	3,224	0	9,856	0.00	13.77	26.00
26.01	RURAL HEALTH CLINIC II	594	0	3,491	0.00	5.55	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	132.89	27.00
28.00	Observation Bed Days		0	233			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: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2023 2:29 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	219	0	311	1.00
2.00	HMO and other (see instructions)			0	20		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	219	0	311	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1326 | Component CCN: 14-3477 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 11/20/2023 2:29 pm

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	611 SOUTH MARSHALL	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MCLEANSBORO	IL	62859	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	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.	N	0	13.00

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		HAMILTON				2.00

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1326
Component CCN: 14-3477

Period:
From 07/01/2022
To 06/30/2023

Worksheet S-8

Date/Time Prepared:
11/20/2023 2:29 pm

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1326 | Component CCN: 14-8529 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 11/20/2023 2:29 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1112 OAK STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CARMI		IL	62869	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			08:00	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.				N	0	13.00
				Provider name		CCN
				1.00		2.00	
14.00	RHC/FQHC name, CCN						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		WHITE				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1326
Component CCN: 14-8529

Period:
From 07/01/2022
To 06/30/2023

Worksheet S-8

Date/Time Prepared:
11/20/2023 2:29 pm

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	15:00	09:00	15:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-10 | Date/Time Prepared: 11/20/2023 2:29 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.508220	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,248,040	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	3,685,496	6.00
7.00	Medicaid cost (line 1 times line 6)	1,873,043	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	49,204	0	49,204	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	25,006	0	25,006	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	25,006	0	25,006	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	234,378	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	39,240	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	60,368	27.01
28.00	Non-Medicare bad debt expense (see instructions)	174,010	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	109,563	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	134,569	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	134,569	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/20/2023 2:29 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,019,551	1,019,551	876,950	1,896,501	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		524,495	524,495	40,596	565,091	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	97,080	1,379,151	1,476,231	0	1,476,231	4.00
5.01	00540	NONPATIENT TELEPHONES	0	64,397	64,397	13,133	77,530	5.01
5.02	00550	DATA PROCESSING	126,497	766,191	892,688	-5,959	886,729	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	68,810	727	69,537	-7	69,530	5.03
5.04	00570	ADMITTING	0	0	0	153,507	153,507	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	404,354	110,980	515,334	-153,924	361,410	5.05
5.06	00590	OTHER ADMIN & GENERAL	400,317	767,085	1,167,402	-47,908	1,119,494	5.06
7.00	00700	OPERATION OF PLANT	179,482	638,477	817,959	-2,800	815,159	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	109,054	109,054	0	109,054	8.00
9.00	00900	HOUSEKEEPING	224,103	49,839	273,942	-1,685	272,257	9.00
10.00	01000	DIETARY	0	113,134	113,134	0	113,134	10.00
13.00	01300	NURSING ADMINISTRATION	351,177	61,782	412,959	-15	412,944	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	5,579	5,579	-4,514	1,065	14.00
15.00	01500	PHARMACY	197,788	281,955	479,743	-197,231	282,512	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	184,866	47,946	232,812	-8	232,804	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	108,297	108,297	0	108,297	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,704,188	218,492	1,922,680	-57,156	1,865,524	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	260,185	266,442	526,627	-155,267	371,360	50.00
53.00	05300	ANESTHESIOLOGY	0	6,084	6,084	-3,831	2,253	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	377,538	435,304	812,842	-526	812,316	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	614,855	689,924	1,304,779	-19,490	1,285,289	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	80,876	63,192	144,068	-37,434	106,634	65.00
66.00	06600	PHYSICAL THERAPY	555,956	8,840	564,796	-193,101	371,695	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	165,786	165,786	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	26,918	26,918	68.00
69.00	06900	ELECTROCARDIOLOGY	0	51,602	51,602	0	51,602	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	117,579	117,579	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	104,185	104,185	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	260,349	260,349	73.00
76.00	03610	SLEEP LAB	0	21,600	21,600	0	21,600	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	229,115	121,801	350,916	-5,182	345,734	76.01
76.02	03020	WOUND CARE	0	102,383	102,383	0	102,383	76.02
76.97	07697	CARDIAC REHABILITATION	49,529	1,946	51,475	-209	51,266	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,473,277	443,331	1,916,608	0	1,916,608	88.00
88.01	08801	RURAL HEALTH CLINIC II	448,476	125,716	574,192	-105,670	468,522	88.01
91.00	09100	EMERGENCY	769,232	1,530,058	2,299,290	-22,272	2,277,018	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		744,814	744,814	-744,814	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,797,701	10,880,169	19,677,870	0	19,677,870	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
200.00		TOTAL (SUM OF LINES 118 through 199)	8,797,701	10,880,169	19,677,870	0	19,677,870	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/20/2023 2:29 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	-61,730	1,834,771		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	565,091		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-318,809	1,157,422		4.00
5.01	00540	NONPATIENT TELEPHONES	-4,408	73,122		5.01
5.02	00550	DATA PROCESSING	-350	886,379		5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	69,530		5.03
5.04	00570	ADMITTING	0	153,507		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	361,410		5.05
5.06	00590	OTHER ADMIN & GENERAL	-344,903	774,591		5.06
7.00	00700	OPERATION OF PLANT	0	815,159		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	109,054		8.00
9.00	00900	HOUSEKEEPING	0	272,257		9.00
10.00	01000	DIETARY	0	113,134		10.00
13.00	01300	NURSING ADMINISTRATION	0	412,944		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	1,065		14.00
15.00	01500	PHARMACY	-18	282,494		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,849	229,955		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-108,297	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-348,666	1,516,858		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-82,915	288,445		50.00
53.00	05300	ANESTHESIOLOGY	0	2,253		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,013	808,303		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	-43,795	1,241,494		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	106,634		65.00
66.00	06600	PHYSICAL THERAPY	0	371,695		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	165,786		67.00
68.00	06800	SPEECH PATHOLOGY	0	26,918		68.00
69.00	06900	ELECTROCARDIOLOGY	-16,784	34,818		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,682	141,261		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	104,185		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	260,349		73.00
76.00	03610	SLEEP LAB	0	21,600		76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	345,734		76.01
76.02	03020	WOUND CARE	-55,113	47,270		76.02
76.97	07697	CARDIAC REHABILITATION	-1,470	49,796		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-472	1,916,136		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	468,522		88.01
91.00	09100	EMERGENCY	-1,057,210	1,219,808		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,428,120	17,249,750		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,428,120	17,249,750		200.00

RECLASSIFICATIONS | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/20/2023 2:29 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	47,734		1.00
	0		0	47,734		
	B - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	744,814		1.00
	0		0	744,814		
	C - ADMITTING					
1.00	ADMITTING	5.04	134,785	18,722		1.00
	0		134,785	18,722		
	D - IMPLANTS					
1.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	104,185		1.00
	0		0	104,185		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	117,579		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
	0		0	117,579		
	G - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	260,349		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
	0		0	260,349		
	H - OVERHEAD EXPENSES					
1.00	NONPATIENT TELEPHONES	5.01	0	13,133		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	13,133		
	I - RENT & LEASE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	95,242		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	29,756		2.00
3.00	DATA PROCESSING	5.02	0	4,544		3.00
4.00		0.00	0	0		4.00
	0		0	129,542		
	J - UTILITY EXPENSE					
1.00	OPERATION OF PLANT	7.00	0	12,962		1.00
2.00		0.00	0	0		2.00
	0		0	12,962		
	K - PT/OT/ST					
1.00	OCCUPATIONAL THERAPY	67.00	163,021	2,765		1.00
2.00	SPEECH PATHOLOGY	68.00	26,816	102		2.00
	0		189,837	2,867		
500.00	Grand Total: Increases		324,622	1,451,887		500.00

RECLASSIFICATIONS | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/20/2023 2:29 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PROPERTY INSURANCE						
1.00	OTHER ADMIN & GENERAL	5.06	0	47,734	12		1.00
	0		0	47,734			
	B - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	744,814	11		1.00
	0		0	744,814			
	C - ADMITTING						
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	134,785	18,722	0		1.00
	0		134,785	18,722			
	D - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	104,185	0		1.00
	0		0	104,185			
	F - MEDICAL SUPPLIES						
1.00	PURCHASING RECEIVING AND STORES	5.03	0	7	0		1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	417	0		2.00
3.00	OPERATION OF PLANT	7.00	0	26	0		3.00
4.00	HOUSEKEEPING	9.00	0	1,685	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	15	0		5.00
6.00	CENTRAL SERVICE & SUPPLY	14.00	0	549	0		6.00
7.00	PHARMACY	15.00	0	100	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	8	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	26,175	0		9.00
10.00	OPERATING ROOM	50.00	0	45,889	0		10.00
11.00	ANESTHESIOLOGY	53.00	0	3,760	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	86	0		12.00
13.00	LABORATORY	60.00	0	1,150	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	21,488	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	393	0		15.00
16.00	SENIOR ENRICHMENT CENTER	76.01	0	18	0		16.00
17.00	CARDIAC REHABILITATION	76.97	0	209	0		17.00
18.00	EMERGENCY	91.00	0	15,430	0		18.00
19.00	OTHER ADMIN & GENERAL	5.06	0	174	0		19.00
	0		0	117,579			
	G - DRUGS						
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	3,965	0		1.00
2.00	PHARMACY	15.00	0	196,897	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	30,981	0		3.00
4.00	OPERATING ROOM	50.00	0	5,193	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	71	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	440	0		6.00
7.00	LABORATORY	60.00	0	10	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	15,946	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	4	0		9.00
10.00	EMERGENCY	91.00	0	6,842	0		10.00
	0		0	260,349			
	H - OVERHEAD EXPENSES						
1.00	DATA PROCESSING	5.02	0	10,503	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	2,630	0		2.00
	TOTALS		0	13,133			
	I - RENT & LEASE EXPENSE						
1.00	OPERATION OF PLANT	7.00	0	15,736	10		1.00
2.00	PHARMACY	15.00	0	234	10		2.00
3.00	LABORATORY	60.00	0	18,330	0		3.00
4.00	RURAL HEALTH CLINIC II	88.01	0	95,242	0		4.00
	0		0	129,542			
	J - UTILITY EXPENSE						
1.00	SENIOR ENRICHMENT CENTER	76.01	0	5,164	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	7,798	0		2.00
	0		0	12,962			
	K - PT/OT/ST						
1.00	PHYSICAL THERAPY	66.00	189,837	2,867	0		1.00
2.00		0.00	0	0	0		2.00
	0		189,837	2,867			
500.00	Grand Total: Decreases		324,622	1,451,887			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 11/20/2023 2:29 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	69,760	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	23,251,443	368,507	0	368,507	1,979,182	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	8,886,646	1,204,537	0	1,204,537	3,712,487	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,207,849	1,573,044	0	1,573,044	5,691,669	8.00
9.00	Reconciling Items	-270,311	119,799	0	119,799	0	9.00
10.00	Total (line 8 minus line 9)	32,478,160	1,453,245	0	1,453,245	5,691,669	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	69,760	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	21,640,768	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	6,378,696	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,089,224	0	8.00
9.00	Reconciling Items	-150,512	0	9.00
10.00	Total (line 8 minus line 9)	28,239,736	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 11/20/2023 2:29 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,019,551	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	524,495	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,544,046	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1,019,551		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	524,495		2.00
3.00	Total (sum of lines 1-2)	0	1,544,046		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part III | Date/Time Prepared: 11/20/2023 2:29 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	21,710,528	0	21,710,528	0.772913	36,894	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,378,696	0	6,378,696	0.227087	10,840	2.00
3.00	Total (sum of lines 1-2)	28,089,224	0	28,089,224	1.000000	47,734	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	36,894	1,019,551	95,242	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	10,840	524,495	29,756	2.00
3.00	Total (sum of lines 1-2)	0	0	47,734	1,544,046	124,998	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	683,084	36,894	0	0	1,834,771	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	10,840	0	0	565,091	2.00
3.00	Total (sum of lines 1-2)	683,084	47,734	0	0	2,399,862	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/20/2023 2:29 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-80,009	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		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	-1,564,233			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-1,016	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	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	-2,849	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	-1,391	OTHER ADMIN & GENERAL	5.06	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-108,297	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	WOMEN'S WELLNESS	B	-43,155	LABORATORY	60.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/20/2023 2:29 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	NURSING CENTER LAB SERVICES	B	-640	LABORATORY	60.00	0	33.01
33.02	SELF INSURED DOMESTIC CLAIMS EXPENSE	A	-284,791	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.04	MISCELLANEOUS REVENUE	B	-1,938	ADULTS & PEDIATRICS	30.00	0	33.04
34.00	NON-ALLOWABLE FUNDRAISING	A	-87,439	OTHER ADMIN & GENERAL	5.06	0	34.00
34.01	NON-ALLOWABLE ADVERTISING	A	-129,935	OTHER ADMIN & GENERAL	5.06	0	34.01
34.03	NON-ALLOWABLE FUNDRAISING BENEFITS	A	-4,049	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.03
34.04	MARKETING/ADVERTISING - RHC I	A	-472	RURAL HEALTH CLINIC	88.00	0	34.04
34.05	MARKETING/ADVERTISING - IT	A	-350	DATA PROCESSING	5.02	0	34.05
35.00	NON-ALLOWABLE LOBBYING DUES	A	-7,256	OTHER ADMIN & GENERAL	5.06	0	35.00
35.01	NON-ALLOWABLE PATIENT TELEPHONE EXPE	A	-4,408	NONPATIENT TELEPHONES	5.01	0	35.01
36.00	BOND ISSUANCE COSTS	A	18,279	CAP REL COSTS-BLDG & FIXT	1.00	11	36.00
37.00	INVENTORY ADJUSTMENT	A	24,698	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	37.00
38.00	340B PROGRAM COSTS	A	-118,882	OTHER ADMIN & GENERAL	5.06	0	38.00
38.01	340B PROGRAM COSTS	A	-18	PHARMACY	15.00	0	38.01
39.00	PHYSICIAN BENEFITS	A	-29,969	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,428,120				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 11/20/2023 2:29 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	346,728	346,728	0	0	0	1.00
2.00	50.00	OPERATING ROOM	82,915	82,915	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	4,013	4,013	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	16,784	16,784	0	0	0	4.00
5.00	76.02	WOUND CARE	55,113	55,113	0	0	0	5.00
6.00	76.97	CARDIAC REHABILITATION	1,470	1,470	0	0	0	6.00
7.00	91.00	EMERGENCY	1,468,874	1,057,210	411,664	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			1,975,897	1,564,233	411,664		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	76.02	WOUND CARE	0	0	0	0	0	5.00
6.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	346,728		1.00
2.00	50.00	OPERATING ROOM	0	0	0	82,915		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	4,013		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	16,784		4.00
5.00	76.02	WOUND CARE	0	0	0	55,113		5.00
6.00	76.97	CARDIAC REHABILITATION	0	0	0	1,470		6.00
7.00	91.00	EMERGENCY	0	0	0	1,057,210		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	1,564,233		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/20/2023 2:29 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,834,771	1,834,771				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	565,091		565,091			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,157,422	6,749	0	1,164,171		4.00
5.01	00540	NONPATIENT TELEPHONES	73,122	900	0	0	74,022	5.01
5.02	00550	DATA PROCESSING	886,379	37,703	143,283	17,589	1,163	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	69,530	51,066	24	9,568	1,163	5.03
5.04	00570	ADMITTING	153,507	3,149	0	18,741	1,550	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	361,410	32,619	0	37,482	3,100	5.05
5.06	00590	OTHER ADMIN & GENERAL	774,591	201,991	3,823	49,691	5,426	5.06
7.00	00700	OPERATION OF PLANT	815,159	160,171	26,154	24,956	775	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	109,054	21,506	810	0	0	8.00
9.00	00900	HOUSEKEEPING	272,257	0	1,385	31,160	0	9.00
10.00	01000	DIETARY	113,134	0	0	0	0	10.00
13.00	01300	NURSING ADMINISTRATION	412,944	38,063	779	48,829	3,488	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	1,065	0	0	0	0	14.00
15.00	01500	PHARMACY	282,494	26,388	16,128	27,501	775	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	229,955	14,037	0	25,705	2,325	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,516,858	300,436	61,860	197,323	17,440	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	288,445	150,723	66,942	36,177	2,713	50.00
53.00	05300	ANESTHESIOLOGY	2,253	0	19,537	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	808,303	99,072	146,816	52,495	5,813	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,241,494	38,806	42,477	85,493	3,875	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	106,634	15,747	12,549	11,245	2,325	65.00
66.00	06600	PHYSICAL THERAPY	371,695	65,103	1,078	50,907	2,325	66.00
67.00	06700	OCCUPATIONAL THERAPY	165,786	33,317	552	22,667	775	67.00
68.00	06800	SPEECH PATHOLOGY	26,918	2,700	45	3,729	0	68.00
69.00	06900	ELECTROCARDIOLOGY	34,818	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	141,261	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	104,185	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	260,349	0	0	0	0	73.00
76.00	03610	SLEEP LAB	21,600	8,436	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	345,734	77,386	8,963	31,857	2,713	76.01
76.02	03020	WOUND CARE	47,270	1,012	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	49,796	7,829	0	6,887	388	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,916,136	185,884	4,232	204,853	5,426	88.00
88.01	08801	RURAL HEALTH CLINIC II	468,522	43,327	3,847	62,358	3,875	88.01
91.00	09100	EMERGENCY	1,219,808	103,436	3,807	106,958	5,426	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,249,750	1,727,556	565,091	1,164,171	72,859	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	8,908	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	98,307	0	0	1,163	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,249,750	1,834,771	565,091	1,164,171	74,022	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/20/2023 2:29 pm

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	1,086,117					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	14,105	145,456				5.03
5.04	00570	ADMITTING	35,264	346	212,557			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	63,474	702	0	498,787		5.05
5.06	00590	OTHER ADMIN & GENERAL	49,369	5,284	0	0	1,090,175	5.06
7.00	00700	OPERATION OF PLANT	14,105	6,416	0	0	1,047,736	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1	0	0	131,371	8.00
9.00	00900	HOUSEKEEPING	0	3,721	0	0	308,523	9.00
10.00	01000	DIETARY	0	2,736	0	0	115,870	10.00
13.00	01300	NURSING ADMINISTRATION	56,422	1,037	0	0	561,562	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	112	0	0	1,177	14.00
15.00	01500	PHARMACY	21,158	4,685	0	0	379,129	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	49,369	3,133	0	0	324,524	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	112,843	9,865	87,686	55,801	2,360,112	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	56,422	2,583	1,031	32,477	637,513	50.00
53.00	05300	ANESTHESIOLOGY	7,053	156	22	421	29,442	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,316	6,963	13,171	101,183	1,276,132	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	56,422	56,674	29,573	114,443	1,669,257	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	35,264	1,985	4,572	4,848	195,169	65.00
66.00	06600	PHYSICAL THERAPY	42,316	513	11,665	20,990	566,592	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,158	263	7,786	10,744	263,048	67.00
68.00	06800	SPEECH PATHOLOGY	0	21	472	872	34,757	68.00
69.00	06900	ELECTROCARDIOLOGY	0	136	995	6,263	42,212	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,394	7,986	8,357	169,998	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	10,998	0	2,508	117,691	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	47,199	38,033	345,581	73.00
76.00	03610	SLEEP LAB	0	0	0	2,887	32,923	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	56,422	1,357	0	17,168	541,600	76.01
76.02	03020	WOUND CARE	0	0	0	723	49,005	76.02
76.97	07697	CARDIAC REHABILITATION	0	22	0	1,066	65,988	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	155,159	7,797	0	23,499	2,502,986	88.00
88.01	08801	RURAL HEALTH CLINIC II	98,738	453	0	8,048	689,168	88.01
91.00	09100	EMERGENCY	98,738	5,103	399	48,456	1,592,131	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,086,117	145,456	212,557	498,787	17,141,372	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	8,908	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	99,470	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,086,117	145,456	212,557	498,787	17,249,750	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/20/2023 2:29 pm

		Cost Center Description	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL	1,090,175					5.06
7.00	00700	OPERATION OF PLANT	70,683	1,118,419				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,863	17,944	158,178			8.00
9.00	00900	HOUSEKEEPING	20,814	0	0	329,337		9.00
10.00	01000	DIETARY	7,817	0	0	0	123,687	10.00
13.00	01300	NURSING ADMINISTRATION	37,885	31,759	0	920	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	79	0	0	0	0	14.00
15.00	01500	PHARMACY	25,577	22,017	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,893	11,713	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	159,220	250,675	124,741	102,712	123,687	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,009	125,760	5,811	29,375	0	50.00
53.00	05300	ANESTHESIOLOGY	1,986	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	86,092	82,664	3,038	16,626	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	112,613	32,378	0	12,600	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	13,167	13,139	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	38,224	54,321	14,885	15,085	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,746	27,799	7,318	7,406	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,345	2,252	0	522	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,848	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,469	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	7,940	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,314	0	0	0	0	73.00
76.00	03610	SLEEP LAB	2,221	7,039	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	36,538	64,569	0	12,650	0	76.01
76.02	03020	WOUND CARE	3,306	845	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	4,452	6,532	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	168,859	155,098	1,292	54,674	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	46,493	36,151	0	0	0	88.01
91.00	09100	EMERGENCY	107,410	86,305	1,093	76,767	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,082,863	1,028,960	158,178	329,337	123,687	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	601	7,433	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,711	82,026	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,090,175	1,118,419	158,178	329,337	123,687	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/20/2023 2:29 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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
13.00	01300	NURSING ADMINISTRATION	632,126					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	1,256				14.00
15.00	01500	PHARMACY	0	0	426,723			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	358,130		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	387,083	0	0	78,889	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	49,159	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	143,212	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	665	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	591	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	426,723	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	17,011	0	0	0	0	76.01
76.02	03020	WOUND CARE	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	178,873	0	0	136,029	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	632,126	1,256	426,723	358,130	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	632,126	1,256	426,723	358,130	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/20/2023 2:29 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMIN & GENERAL					5.06
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
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,587,119	-87,816	3,499,303		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	890,627	0	890,627		50.00
53.00	05300	ANESTHESIOLOGY	31,428	0	31,428		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,464,552	0	1,464,552		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	1,970,060	0	1,970,060		60.00
64.00	06400	INTRAVENOUS THERAPY	0	86,889	86,889		64.00
65.00	06500	RESPIRATORY THERAPY	221,475	0	221,475		65.00
66.00	06600	PHYSICAL THERAPY	689,107	0	689,107		66.00
67.00	06700	OCCUPATIONAL THERAPY	323,317	0	323,317		67.00
68.00	06800	SPEECH PATHOLOGY	39,876	0	39,876		68.00
69.00	06900	ELECTROCARDIOLOGY	45,060	0	45,060		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	182,132	0	182,132		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	126,222	0	126,222		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	795,618	0	795,618		73.00
76.00	03610	SLEEP LAB	42,183	0	42,183		76.00
76.01	03950	SENIOR ENRICHMENT CENTER	672,368	0	672,368		76.01
76.02	03020	WOUND CARE	53,156	927	54,083		76.02
76.97	07697	CARDIAC REHABILITATION	76,972	0	76,972		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,882,909	0	2,882,909		88.00
88.01	08801	RURAL HEALTH CLINIC II	771,812	0	771,812		88.01
91.00	09100	EMERGENCY	2,178,608	0	2,178,608		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,044,601	0	17,044,601		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	16,942	0	16,942		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	188,207	0	188,207		192.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	17,249,750	0	17,249,750		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/20/2023 2:29 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,749	0	6,749	6,749	4.00
5.01	00540	NONPATIENT TELEPHONES	0	900	0	900	0	5.01
5.02	00550	DATA PROCESSING	0	37,703	143,283	180,986	102	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	51,066	24	51,090	55	5.03
5.04	00570	ADMITTING	0	3,149	0	3,149	109	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	32,619	0	32,619	217	5.05
5.06	00590	OTHER ADMIN & GENERAL	0	201,991	3,823	205,814	288	5.06
7.00	00700	OPERATION OF PLANT	0	160,171	26,154	186,325	145	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,506	810	22,316	0	8.00
9.00	00900	HOUSEKEEPING	0	0	1,385	1,385	181	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
13.00	01300	NURSING ADMINISTRATION	0	38,063	779	38,842	283	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	26,388	16,128	42,516	159	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,037	0	14,037	149	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	300,436	61,860	362,296	1,144	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	150,723	66,942	217,665	210	50.00
53.00	05300	ANESTHESIOLOGY	0	0	19,537	19,537	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	99,072	146,816	245,888	304	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	38,806	42,477	81,283	496	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	15,747	12,549	28,296	65	65.00
66.00	06600	PHYSICAL THERAPY	0	65,103	1,078	66,181	295	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	33,317	552	33,869	131	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,700	45	2,745	22	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
76.00	03610	SLEEP LAB	0	8,436	0	8,436	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	77,386	8,963	86,349	185	76.01
76.02	03020	WOUND CARE	0	1,012	0	1,012	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	7,829	0	7,829	40	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	185,884	4,232	190,116	1,188	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	43,327	3,847	47,174	361	88.01
91.00	09100	EMERGENCY	0	103,436	3,807	107,243	620	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,727,556	565,091	2,292,647	6,749	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	8,908	0	8,908	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	98,307	0	98,307	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,834,771	565,091	2,399,862	6,749	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/20/2023 2:29 pm

		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	900					5.01
5.02	00550	DATA PROCESSING	14	181,102				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	14	2,352	53,511			5.03
5.04	00570	ADMITTING	19	5,880	127	9,284		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	38	10,584	258	0	43,716	5.05
5.06	00590	OTHER ADMIN & GENERAL	66	8,232	1,944	0	0	5.06
7.00	00700	OPERATION OF PLANT	9	2,352	2,360	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	1,369	0	0	9.00
10.00	01000	DIETARY	0	0	1,007	0	0	10.00
13.00	01300	NURSING ADMINISTRATION	42	9,408	381	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	41	0	0	14.00
15.00	01500	PHARMACY	9	3,528	1,723	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28	8,232	1,153	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	214	18,816	3,629	3,829	4,889	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33	9,408	950	45	2,845	50.00
53.00	05300	ANESTHESIOLOGY	0	1,176	57	1	37	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	71	7,056	2,562	575	8,865	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	47	9,408	20,851	1,292	10,044	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	28	5,880	730	200	425	65.00
66.00	06600	PHYSICAL THERAPY	28	7,056	189	510	1,839	66.00
67.00	06700	OCCUPATIONAL THERAPY	9	3,528	97	340	941	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	8	21	76	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	50	43	549	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	4,560	349	732	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	4,046	0	220	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,062	3,332	73.00
76.00	03610	SLEEP LAB	0	0	0	0	253	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	33	9,408	499	0	1,504	76.01
76.02	03020	WOUND CARE	0	0	0	0	63	76.02
76.97	07697	CARDIAC REHABILITATION	5	0	8	0	93	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	66	25,870	2,868	0	2,059	88.00
88.01	08801	RURAL HEALTH CLINIC II	47	16,464	167	0	705	88.01
91.00	09100	EMERGENCY	66	16,464	1,877	17	4,245	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	886	181,102	53,511	9,284	43,716	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	14	0	0	0	0	192.00
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)	900	181,102	53,511	9,284	43,716	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/20/2023 2:29 pm

		Cost Center Description	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL	216,344					5.06
7.00	00700	OPERATION OF PLANT	14,027	205,218				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,759	3,293	27,368			8.00
9.00	00900	HOUSEKEEPING	4,131	0	0	7,066		9.00
10.00	01000	DIETARY	1,551	0	0	0	2,558	10.00
13.00	01300	NURSING ADMINISTRATION	7,518	5,827	0	20	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	16	0	0	0	0	14.00
15.00	01500	PHARMACY	5,076	4,040	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,345	2,149	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,597	45,995	21,583	2,204	2,558	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,535	23,076	1,005	630	0	50.00
53.00	05300	ANESTHESIOLOGY	394	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,085	15,168	526	357	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	22,348	5,941	0	270	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,613	2,411	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	7,586	9,967	2,575	324	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,522	5,101	1,266	159	0	67.00
68.00	06800	SPEECH PATHOLOGY	465	413	0	11	0	68.00
69.00	06900	ELECTROCARDIOLOGY	565	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,276	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,576	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,627	0	0	0	0	73.00
76.00	03610	SLEEP LAB	441	1,292	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	7,251	11,848	0	271	0	76.01
76.02	03020	WOUND CARE	656	155	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	883	1,199	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	33,508	28,459	224	1,173	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	9,227	6,633	0	0	0	88.01
91.00	09100	EMERGENCY	21,315	15,836	189	1,647	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	214,893	188,803	27,368	7,066	2,558	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	119	1,364	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,332	15,051	0	0	0	192.00
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)	216,344	205,218	27,368	7,066	2,558	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/20/2023 2:29 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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
13.00	01300	NURSING ADMINISTRATION	62,321					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	57				14.00
15.00	01500	PHARMACY	0	0	57,051			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	30,093		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,162	0	0	6,629		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,847	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0	12,034		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	30	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	27	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	57,051	0		73.00
76.00	03610	SLEEP LAB	0	0	0	0		76.00
76.01	03950	SENIOR ENRICHMENT CENTER	1,677	0	0	0		76.01
76.02	03020	WOUND CARE	0	0	0	0		76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0		88.01
91.00	09100	EMERGENCY	17,635	0	0	11,430		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,321	57	57,051	30,093	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	62,321	57	57,051	30,093	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/20/2023 2:29 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMIN & GENERAL					5.06
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
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	543,545	0	543,545		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	269,249	0	269,249		50.00
53.00	05300	ANESTHESIOLOGY	21,202	0	21,202		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	298,457	0	298,457		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	164,014	0	164,014		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	40,648	0	40,648		65.00
66.00	06600	PHYSICAL THERAPY	96,550	0	96,550		66.00
67.00	06700	OCCUPATIONAL THERAPY	48,963	0	48,963		67.00
68.00	06800	SPEECH PATHOLOGY	3,761	0	3,761		68.00
69.00	06900	ELECTROCARDIOLOGY	1,207	0	1,207		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,947	0	7,947		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	5,869	0	5,869		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	67,072	0	67,072		73.00
76.00	03610	SLEEP LAB	10,422	0	10,422		76.00
76.01	03950	SENIOR ENRICHMENT CENTER	119,025	0	119,025		76.01
76.02	03020	WOUND CARE	1,886	0	1,886		76.02
76.97	07697	CARDIAC REHABILITATION	10,057	0	10,057		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	285,531	0	285,531		88.00
88.01	08801	RURAL HEALTH CLINIC II	80,778	0	80,778		88.01
91.00	09100	EMERGENCY	198,584	0	198,584		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,274,767	0	2,274,767		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	10,391	0	10,391		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	114,704	0	114,704		192.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,399,862	0	2,399,862		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/20/2023 2:29 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (MACHINES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	81,560					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		554,251				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	300	0	8,372,622			4.00
5.01	00540	NONPATIENT TELEPHONES	40	0	0	191		5.01
5.02	00550	DATA PROCESSING	1,676	140,534	126,497	3	154	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	2,270	24	68,810	3	2	5.03
5.04	00570	ADMITTING	140	0	134,785	4	5	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,450	0	269,569	8	9	5.05
5.06	00590	OTHER ADMIN & GENERAL	8,979	3,750	357,373	14	7	5.06
7.00	00700	OPERATION OF PLANT	7,120	25,652	179,482	2	2	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	956	794	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	1,358	224,103	0	0	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
13.00	01300	NURSING ADMINISTRATION	1,692	764	351,177	9	8	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,173	15,819	197,788	2	3	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	624	0	184,866	6	7	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,355	60,673	1,419,133	45	16	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,700	65,658	260,185	7	8	50.00
53.00	05300	ANESTHESIOLOGY	0	19,162	0	0	1	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,404	144,002	377,538	15	6	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,725	41,662	614,855	10	8	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	700	12,308	80,876	6	5	65.00
66.00	06600	PHYSICAL THERAPY	2,894	1,057	366,119	6	6	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,481	541	163,021	2	3	67.00
68.00	06800	SPEECH PATHOLOGY	120	44	26,816	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
76.00	03610	SLEEP LAB	375	0	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	3,440	8,791	229,115	7	8	76.01
76.02	03020	WOUND CARE	45	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	348	0	49,529	1	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,263	4,151	1,473,277	14	22	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,926	3,773	448,476	10	14	88.01
91.00	09100	EMERGENCY	4,598	3,734	769,232	14	14	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,794	554,251	8,372,622	188	154	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	396	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,370	0	0	3	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,834,771	565,091	1,164,171	74,022	1,086,117	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.495966	1.019558	0.139045	387.549738	7,052.707792	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			6,749	900	181,102	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000806	4.712042	1,175.987013	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: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/20/2023 2:29 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	ADMITTING (INPATIENT CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	1,377,882					5.03
5.04	00570	ADMITTING	3,277	7,351,590				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	6,654	0	33,537,870			5.05
5.06	00590	OTHER ADMIN & GENERAL	50,058	0	0	-1,090,175	16,159,575	5.06
7.00	00700	OPERATION OF PLANT	60,775	0	0	0	1,047,736	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11	0	0	0	131,371	8.00
9.00	00900	HOUSEKEEPING	35,252	0	0	0	308,523	9.00
10.00	01000	DIETARY	25,918	0	0	0	115,870	10.00
13.00	01300	NURSING ADMINISTRATION	9,821	0	0	0	561,562	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	1,065	0	0	0	1,177	14.00
15.00	01500	PHARMACY	44,378	0	0	0	379,129	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29,680	0	0	0	324,524	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	93,452	3,032,755	3,752,115	0	2,360,112	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,472	35,660	2,183,788	0	637,513	50.00
53.00	05300	ANESTHESIOLOGY	1,478	775	28,283	0	29,442	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,961	455,555	6,803,596	0	1,276,132	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	536,836	1,022,812	7,694,366	0	1,669,257	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	18,807	158,124	325,968	0	195,169	65.00
66.00	06600	PHYSICAL THERAPY	4,860	403,438	1,411,406	0	566,592	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,487	269,300	722,431	0	263,048	67.00
68.00	06800	SPEECH PATHOLOGY	202	16,318	58,660	0	34,757	68.00
69.00	06900	ELECTROCARDIOLOGY	1,291	34,399	421,106	0	42,212	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	117,405	276,199	561,920	0	169,998	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	104,185	0	168,629	0	117,691	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,632,454	2,557,374	0	345,581	73.00
76.00	03610	SLEEP LAB	0	0	194,138	0	32,923	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	12,854	0	1,154,377	0	541,600	76.01
76.02	03020	WOUND CARE	0	0	48,612	0	49,005	76.02
76.97	07697	CARDIAC REHABILITATION	212	0	71,661	0	65,988	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	73,859	0	1,580,097	0	2,502,986	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,291	0	541,168	0	689,168	88.01
91.00	09100	EMERGENCY	48,341	13,801	3,258,175	0	1,592,131	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,377,882	7,351,590	33,537,870	-1,090,175	16,051,197	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	8,908	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	99,470	192.00
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)	145,456	212,557	498,787		1,090,175	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.105565	0.028913	0.014872		0.067463	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	53,511	9,284	43,716		216,344	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.038836	0.001263	0.001303		0.013388	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: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/20/2023 2:29 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	
			7.00	8.00	9.00	10.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
7.00	00700	OPERATION OF PLANT	59,585					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	956	30,976				8.00
9.00	00900	HOUSEKEEPING	0	0	13,252			9.00
10.00	01000	DIETARY	0	0	0	9,119		10.00
13.00	01300	NURSING ADMINISTRATION	1,692	0	37	0	78,220	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,173	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	624	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,355	24,428	4,133	9,119	47,898	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,700	1,138	1,182	0	6,083	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,404	595	669	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,725	0	507	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	700	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,894	2,915	607	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,481	1,433	298	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	120	0	21	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
76.00	03610	SLEEP LAB	375	0	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	3,440	0	509	0	2,105	76.01
76.02	03020	WOUND CARE	45	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	348	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,263	253	2,200	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,926	0	0	0	0	88.01
91.00	09100	EMERGENCY	4,598	214	3,089	0	22,134	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,819	30,976	13,252	9,119	78,220	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	396	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,370	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,118,419	158,178	329,337	123,687	632,126	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.770143	5.106470	24.851871	13.563658	8.081386	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	205,218	27,368	7,066	2,558	62,321	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.444122	0.883523	0.533203	0.280513	0.796740	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: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/20/2023 2:29 pm

		Cost Center Description	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			14.00	15.00	16.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	221,590					14.00
15.00	01500	PHARMACY	0	260,349				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	27,170			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	5,985	0		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
60.00	06000	LABORATORY	0	0	10,865	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	117,405	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	104,185	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	260,349	0	0		73.00
76.00	03610	SLEEP LAB	0	0	0	0		76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	0	0	0		76.01
76.02	03020	WOUND CARE	0	0	0	0		76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0		88.01
91.00	09100	EMERGENCY	0	0	10,320	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	221,590	260,349	27,170	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,256	426,723	358,130	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.005668	1.639042	13.181082	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	57	57,051	30,093	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000257	0.219133	1.107582	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-2 | Date/Time Prepared: 11/20/2023 2:29 pm

		Description	Worksheet CODE	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		ADULTS & PEDIATRICS	1	30.00	-87,816	7.00
8.00		IV THERAPY	1	64.00	86,889	8.00
9.00		WOUND THERAPY	1	76.02	927	9.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/20/2023 2:29 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,499,303		3,499,303	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	890,627		890,627	0	0	50.00
53.00	05300	ANESTHESIOLOGY	31,428		31,428	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,464,552		1,464,552	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	1,970,060		1,970,060	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	86,889		86,889	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	221,475	0	221,475	0	0	65.00
66.00	06600	PHYSICAL THERAPY	689,107	0	689,107	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	323,317	0	323,317	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	39,876	0	39,876	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	45,060		45,060	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	182,132		182,132	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	126,222		126,222	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	795,618		795,618	0	0	73.00
76.00	03610	SLEEP LAB	42,183		42,183	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	672,368		672,368	0	0	76.01
76.02	03020	WOUND CARE	54,083		54,083	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	76,972		76,972	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,882,909		2,882,909	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	771,812		771,812	0	0	88.01
91.00	09100	EMERGENCY	2,178,608		2,178,608	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	265,944		265,944		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,310,545	0	17,310,545	0	0	200.00
201.00		Less Observation Beds	265,944		265,944		0	201.00
202.00		Total (see instructions)	17,044,601	0	17,044,601	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/20/2023 2:29 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,959,767		2,959,767			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,660	2,148,128	2,183,788	0.407836	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	775	27,508	28,283	1.111198	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	455,555	6,348,041	6,803,596	0.215261	0.000000	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	1,022,812	6,671,554	7,694,366	0.256039	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	51,382	229,837	281,219	0.308973	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	158,124	167,844	325,968	0.679438	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	403,438	1,007,968	1,411,406	0.488242	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	269,300	453,131	722,431	0.447540	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	16,318	42,342	58,660	0.679782	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	34,399	386,707	421,106	0.107004	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	276,199	285,721	561,920	0.324124	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	168,629	168,629	0.748519	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,632,454	924,920	2,557,374	0.311107	0.000000	73.00
76.00	03610	SLEEP LAB	0	194,138	194,138	0.217284	0.000000	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	1,154,377	1,154,377	0.582451	0.000000	76.01
76.02	03020	WOUND CARE	0	48,612	48,612	1.112544	0.000000	76.02
76.97	07697	CARDIAC REHABILITATION	0	71,661	71,661	1.074113	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,580,097	1,580,097			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	541,168	541,168			88.01
91.00	09100	EMERGENCY	13,801	3,244,374	3,258,175	0.668659	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	21,606	489,523	511,129	0.520307	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,351,590	26,186,280	33,537,870			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,351,590	26,186,280	33,537,870			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/20/2023 2:29 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
76.00	03610	SLEEP LAB	0.000000		76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0.000000		76.01
76.02	03020	WOUND CARE	0.000000		76.02
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		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: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 11/20/2023 2:29 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	269,249	2,183,788	0.123294	15,266	1,882	50.00
53.00	05300	ANESTHESIOLOGY	21,202	28,283	0.749638	775	581	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	298,457	6,803,596	0.043868	299,417	13,135	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	164,014	7,694,366	0.021316	582,615	12,419	60.00
64.00	06400	INTRAVENOUS THERAPY	0	281,219	0.000000	6,115	0	64.00
65.00	06500	RESPIRATORY THERAPY	40,648	325,968	0.124699	72,649	9,059	65.00
66.00	06600	PHYSICAL THERAPY	96,550	1,411,406	0.068407	14,936	1,022	66.00
67.00	06700	OCCUPATIONAL THERAPY	48,963	722,431	0.067775	6,342	430	67.00
68.00	06800	SPEECH PATHOLOGY	3,761	58,660	0.064115	1,602	103	68.00
69.00	06900	ELECTROCARDIOLOGY	1,207	421,106	0.002866	22,426	64	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,947	561,920	0.014143	116,907	1,653	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	5,869	168,629	0.034804	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	67,072	2,557,374	0.026227	531,118	13,930	73.00
76.00	03610	SLEEP LAB	10,422	194,138	0.053683	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	119,025	1,154,377	0.103108	0	0	76.01
76.02	03020	WOUND CARE	1,886	48,612	0.038797	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	10,057	71,661	0.140341	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	285,531	1,580,097	0.180705	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	80,778	541,168	0.149266	0	0	88.01
91.00	09100	EMERGENCY	198,584	3,258,175	0.060949	4,535	276	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	41,309	511,129	0.080819	1,909	154	92.00
200.00		Total (lines 50 through 199)	1,772,531	30,578,103		1,676,612	54,708	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/20/2023 2:29 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	0	0	0	0	76.01
76.02	03020	WOUND CARE	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/20/2023 2:29 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	2,183,788	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	28,283	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,803,596	0.000000	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	7,694,366	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	281,219	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	325,968	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,411,406	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	722,431	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	58,660	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	421,106	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	561,920	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	168,629	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,557,374	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	194,138	0.000000	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	0	0	1,154,377	0.000000	76.01
76.02	03020	WOUND CARE	0	0	0	48,612	0.000000	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	71,661	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,580,097	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	541,168	0.000000	88.01
91.00	09100	EMERGENCY	0	0	0	3,258,175	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	511,129	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	30,578,103		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/20/2023 2:29 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	15,266	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	775	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	299,417	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	582,615	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	6,115	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	72,649	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	14,936	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	6,342	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,602	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	22,426	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	116,907	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	531,118	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0.000000	0	0	0	0	76.01
76.02	03020	WOUND CARE	0.000000	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
91.00	09100	EMERGENCY	0.000000	4,535	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,909	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,676,612	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/20/2023 2:29 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.407836	0	1,089,975	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.111198	0	7,466	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.215261	0	2,085,145	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.256039	0	2,430,951	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.308973	0	229,837	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.679438	0	144,151	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.488242	0	389,435	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.447540	0	137,754	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.679782	0	7,946	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.107004	0	150,024	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.324124	0	82,265	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.748519	0	110,373	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.311107	0	365,100	0	0	73.00
76.00	03610	SLEEP LAB	0.217284	0	59,098	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0.582451	0	1,034,761	0	0	76.01
76.02	03020	WOUND CARE	1.112544	0	48,611	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	1.074113	0	28,365	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
91.00	09100	EMERGENCY	0.668659	0	985,714	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.520307	0	206,243	0	0	92.00
200.00		Subtotal (see instructions)		0	9,593,214	0	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	9,593,214	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/20/2023 2:29 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	444,531	0		50.00
53.00	05300	ANESTHESIOLOGY	8,296	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	448,850	0		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	622,418	0		60.00
64.00	06400	INTRAVENOUS THERAPY	71,013	0		64.00
65.00	06500	RESPIRATORY THERAPY	97,942	0		65.00
66.00	06600	PHYSICAL THERAPY	190,139	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	61,650	0		67.00
68.00	06800	SPEECH PATHOLOGY	5,402	0		68.00
69.00	06900	ELECTROCARDIOLOGY	16,053	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,664	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	82,616	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	113,585	0		73.00
76.00	03610	SLEEP LAB	12,841	0		76.00
76.01	03950	SENIOR ENRICHMENT CENTER	602,698	0		76.01
76.02	03020	WOUND CARE	54,082	0		76.02
76.97	07697	CARDIAC REHABILITATION	30,467	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
91.00	09100	EMERGENCY	659,107	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	107,310	0		92.00
200.00		Subtotal (see instructions)	3,655,664	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,655,664	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/20/2023 2:29 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)	3,141	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,165	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)	932	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	720	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	1,164	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	92	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	676	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)	720	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)	945	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	188.44	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)	3,499,303	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	19,200	25.00
26.00	Total swing-bed cost (see instructions)	2,169,579	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,329,724	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,329,724	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)	1,141.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	771,580	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)	771,580	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/20/2023 2:29 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	492,732	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,264,312	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	821,801	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,078,614	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	1,900,415	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	233	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,141.39	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	265,944	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/20/2023 2:29 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	543,545	3,499,303	0.155330	265,944	41,309	90.00
91.00	Nursing Program cost	0	3,499,303	0.000000	265,944	0	91.00
92.00	Allied health cost	0	3,499,303	0.000000	265,944	0	92.00
93.00	All other Medical Education	0	3,499,303	0.000000	265,944	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/20/2023 2:29 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		721,615		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.407836	15,266	6,226	50.00
53.00	05300	ANESTHESIOLOGY	1.111198	775	861	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.215261	299,417	64,453	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.256039	582,615	149,172	60.00
64.00	06400	INTRAVENOUS THERAPY	0.308973	6,115	1,889	64.00
65.00	06500	RESPIRATORY THERAPY	0.679438	72,649	49,360	65.00
66.00	06600	PHYSICAL THERAPY	0.488242	14,936	7,292	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.447540	6,342	2,838	67.00
68.00	06800	SPEECH PATHOLOGY	0.679782	1,602	1,089	68.00
69.00	06900	ELECTROCARDIOLOGY	0.107004	22,426	2,400	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.324124	116,907	37,892	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.748519	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.311107	531,118	165,235	73.00
76.00	03610	SLEEP LAB	0.217284	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0.582451	0	0	76.01
76.02	03020	WOUND CARE	1.112544	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	1.074113	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	0.668659	4,535	3,032	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.520307	1,909	993	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,676,612	492,732	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,676,612		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1326 | Component CCN: 14-Z326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/20/2023 2:29 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.407836	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.111198	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.215261	57,988	12,483	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.256039	169,478	43,393	60.00
64.00	06400	INTRAVENOUS THERAPY	0.308973	4,344	1,342	64.00
65.00	06500	RESPIRATORY THERAPY	0.679438	46,805	31,801	65.00
66.00	06600	PHYSICAL THERAPY	0.488242	335,983	164,041	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.447540	232,156	103,899	67.00
68.00	06800	SPEECH PATHOLOGY	0.679782	12,968	8,815	68.00
69.00	06900	ELECTROCARDIOLOGY	0.107004	3,041	325	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.324124	96,566	31,299	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.748519	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.311107	693,658	215,802	73.00
76.00	03610	SLEEP LAB	0.217284	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0.582451	0	0	76.01
76.02	03020	WOUND CARE	1.112544	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	1.074113	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	0.668659	1,857	1,242	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.520307	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,654,844	614,442	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,654,844		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1326	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/20/2023 2:29 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,655,664	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,655,664	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	3,692,221	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)	23,990	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,417,828	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,250,403	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	2,250,403	30.00
31.00	Primary payer payments	1	31.00
32.00	Subtotal (line 30 minus line 31)	2,250,402	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)	41,763	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	27,146	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	41,763	36.00
37.00	Subtotal (see instructions)	2,277,548	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,277,548	40.00
40.01	Sequestration adjustment (see instructions)	45,551	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	1,936,785	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)	295,212	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1326	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/20/2023 2:29 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: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/20/2023 2:29 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		751,551		2,052,816	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/13/2023	20,018		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	02/13/2023	116,031	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)		20,018		-116,031	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)		771,569		1,936,785	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		285,296		295,212	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,056,865		2,231,997	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: 14-1326 | Component CCN: 14-Z326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/20/2023 2:29 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		2,011,689		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	02/13/2023	2,518		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)		-2,518		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)		2,009,171		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		379,635		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,388,806		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: 14-1326	Period: From 07/01/2022 To 06/30/2023	Worksheet E-1 Part II Date/Time Prepared: 11/20/2023 2:29 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: 14-1326 | Component CCN: 14-Z326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-2 | Date/Time Prepared: 11/20/2023 2:29 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)	1,919,419	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)	620,586	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	1,665	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)	2,540,005	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,540,005	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)	2,540,005	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	102,811	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	2,437,194	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)	558	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	363	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	558	0	18.00
19.00	Total (see instructions)	2,437,557	0	19.00
19.01	Sequestration adjustment (see instructions)	48,751	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	2,009,171	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)	379,635	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1326	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part V Date/Time Prepared: 11/20/2023 2:29 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,264,312	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)	1,264,312	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,276,955	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)	1,276,955	19.00
20.00	Deductibles (exclude professional component)	203,730	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,073,225	22.00
23.00	Coinsurance	3,890	23.00
24.00	Subtotal (line 22 minus line 23)	1,069,335	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	13,998	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	9,099	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	13,998	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,078,434	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)	1,078,434	30.00
30.01	Sequestration adjustment (see instructions)	21,569	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	771,569	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	285,296	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

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

Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G | Date/Time Prepared: 11/20/2023 2:29 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	7,939,613	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	2,766,563	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	298,973	0	0	0	7.00
8.00	Prepaid expenses	183,288	0	0	0	8.00
9.00	Other current assets	704,821	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	11,893,258	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	69,760	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	21,640,768	0	0	0	15.00
16.00	Accumulated depreciation	-14,505,794	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	6,378,696	0	0	0	23.00
24.00	Accumulated depreciation	-3,989,653	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	150,512	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	9,744,289	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,211,497	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	105,651	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,317,148	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	24,954,695	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	843,076	0	0	0	37.00
38.00	Salaries, wages, and fees payable	677,229	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	748,000	0	0	0	40.00
41.00	Deferred income	9,875	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	140,686	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,418,866	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	15,232,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15,232,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,650,866	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	7,303,829				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)	7,303,829	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	24,954,695	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-1 | Date/Time Prepared: 11/20/2023 2:29 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		5,475,085		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		675,866				2.00
3.00	Total (sum of line 1 and line 2)		6,150,951		0		3.00
4.00	CAPITAL CONTRIBUTIONS	1,152,878		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)		1,152,878		0		10.00
11.00	Subtotal (line 3 plus line 10)		7,303,829		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)		7,303,829		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	CAPITAL CONTRIBUTIONS		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: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/20/2023 2:29 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,429,444		1,429,444	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,400,775		1,400,775	5.00
6.00	Swing bed - NF	130,601		130,601	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)	2,960,820		2,960,820	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,960,820		2,960,820	17.00
18.00	Ancillary services	4,356,416	20,726,771	25,083,187	18.00
19.00	Outpatient services	35,407	3,761,100	3,796,507	19.00
20.00	RURAL HEALTH CLINIC	0	1,618,369	1,618,369	20.00
20.01	RURAL HEALTH CLINIC II	0	541,168	541,168	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	405,977	478,427	884,404	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,758,620	27,125,835	34,884,455	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		19,677,870		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)		19,677,870		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1326 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-3 | Date/Time Prepared: 11/20/2023 2:29 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	34,884,455	1.00
2.00	Less contractual allowances and discounts on patients' accounts	15,942,253	2.00
3.00	Net patient revenues (line 1 minus line 2)	18,942,202	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	19,677,870	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-735,668	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	97,535	6.00
7.00	Income from investments	80,006	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	0	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	-23,682	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	2,849	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	1,391	21.00
22.00	Rental of hospital space	28,091	22.00
23.00	Governmental appropriations	758,814	23.00
24.00	340B DRUG REVENUE	484,761	24.00
24.01	WELLNESS PROGRAMS	43,155	24.01
24.02	MISCELLANEOUS INCOME	4,210	24.02
24.50	COVID-19 PHE Funding	5,324	24.50
25.00	Total other income (sum of lines 6-24)	1,482,454	25.00
26.00	Total (line 5 plus line 25)	746,786	26.00
27.00	LOSS ON SALE OF FIXED ASSETS	70,920	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	70,920	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	675,866	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1326 | Component CCN: 14-3477 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/20/2023 2:29 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	642,717	0	642,717	0	642,717	1.00
2.00	Physician Assistant	11,256	0	11,256	0	11,256	2.00
3.00	Nurse Practitioner	353,514	0	353,514	-1,037	352,477	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	265,125	0	265,125	0	265,125	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	126,790	126,790	0	126,790	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)	1,272,612	126,790	1,399,402	-1,037	1,398,365	10.00
11.00	Physician Services Under Agreement	0	135,785	135,785	0	135,785	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	135,785	135,785	0	135,785	14.00
15.00	Medical Supplies	0	51,646	51,646	0	51,646	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	10,081	10,081	0	10,081	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	61,727	61,727	0	61,727	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,272,612	324,302	1,596,914	-1,037	1,595,877	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	1,037	1,037	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	1,037	1,037	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	200,665	119,029	319,694	0	319,694	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	200,665	119,029	319,694	0	319,694	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,473,277	443,331	1,916,608	0	1,916,608	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1326 | Component CCN: 14-3477 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/20/2023 2:29 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	642,717		1.00
2.00	Physician Assistant	0	11,256		2.00
3.00	Nurse Practitioner	0	352,477		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	265,125		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	126,790		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	1,398,365		10.00
11.00	Physician Services Under Agreement	0	135,785		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	135,785		14.00
15.00	Medical Supplies	0	51,646		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	10,081		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	61,727		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,595,877		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	1,037		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	1,037		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-472	319,222		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-472	319,222		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-472	1,916,136		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1326 | Component CCN: 14-8529 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/20/2023 2:29 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	50,153	0	50,153	0	50,153	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	234,169	0	234,169	-290	233,879	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	13,189	0	13,189	0	13,189	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)	297,511	0	297,511	-290	297,221	10.00
11.00	Physician Services Under Agreement	0	7,418	7,418	0	7,418	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	7,418	7,418	0	7,418	14.00
15.00	Medical Supplies	0	10,599	10,599	0	10,599	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	10,599	10,599	0	10,599	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	297,511	18,017	315,528	-290	315,238	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	290	290	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	290	290	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	103,040	103,040	-103,040	0	29.00
30.00	Administrative Costs	150,965	4,659	155,624	-2,630	152,994	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	150,965	107,699	258,664	-105,670	152,994	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	448,476	125,716	574,192	-105,670	468,522	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1326 | Component CCN: 14-8529 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/20/2023 2:29 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	50,153		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	233,879		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	13,189		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	297,221		10.00
11.00	Physician Services Under Agreement	0	7,418		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	7,418		14.00
15.00	Medical Supplies	0	10,599		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	10,599		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	315,238		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	290		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	290		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	152,994		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	152,994		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	468,522		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1326 | Component CCN: 14-3477 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-2 | Date/Time Prepared: 11/20/2023 2:29 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	2.02	3,702	4,200	8,484		1.00
2.00	Physician Assistant	0.08	288	2,100	168		2.00
3.00	Nurse Practitioner	2.28	4,191	2,100	4,788		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.38	8,181		13,440	13,440	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	0.66	1,675			1,675	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)	5.04	9,856			15,115	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,595,877	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,037	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,596,914	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999351	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					319,222	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					966,773	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,285,995	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,285,995	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,285,160	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,881,037	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1326 | Component CCN: 14-8529 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-2 | Date/Time Prepared: 11/20/2023 2:29 pm

RHC II | 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	0.16	288	4,200	672		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.71	3,203	2,100	3,591		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.87	3,491		4,263	4,263	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)	1.87	3,491			4,263	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)					315,238	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					290	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					315,528	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999081	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					152,994	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					303,290	15.00
16.00	Total overhead (sum of lines 14 and 15)					456,284	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					456,284	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					455,865	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					771,103	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1326 Component CCN: 14-3477	Period: From 07/01/2022 To 06/30/2023	Worksheet M-3 Date/Time Prepared: 11/20/2023 2:29 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)			2,881,037	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			56,313	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,824,724	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			15,115	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)			15,115	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			186.88	7.00
		Calculation of Limit (1)			
		Rate Period 1 (07/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 06/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	233.90	242.79		8.00
9.00	Rate for Program covered visits (see instructions)	186.88	186.88		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	1,376	1,553		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	257,147	290,225		11.00
12.00	Program covered visits for mental health services (from contractor records)	127	168		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	23,734	31,396		13.00
14.00	Limit adjustment for mental health services (see instructions)	23,734	31,396		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	602,502		16.00
16.01	Total program charges (see instructions)(from contractor's records)		410,167		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,436		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		5,047		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.)		446,480		16.04
16.05	Total program cost (see instructions)	0	451,527		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		39,355		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		71,793		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		451,527		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		24,286		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		475,813		22.00
23.00	Allowable bad debts (see instructions)		3,477		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		2,260		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,477		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)		478,073		26.00
26.01	Sequestration adjustment (see instructions)		9,561		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		434,057		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)		34,455		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1326 Component CCN: 14-8529	Period: From 07/01/2022 To 06/30/2023	Worksheet M-3 Date/Time Prepared: 11/20/2023 2:29 pm
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			771,103	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			12,277	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			758,826	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,263	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)			4,263	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			178.00	7.00
		Calculation of Limit (1)			
		Rate Period 1 (07/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 06/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	206.05	213.88		8.00
9.00	Rate for Program covered visits (see instructions)	178.00	178.00		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	307	287		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	54,646	51,086		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	105,732		16.00
16.01	Total program charges (see instructions)(from contractor's records)		76,653		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		500		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		690		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.)		75,063		16.04
16.05	Total program cost (see instructions)	0	75,753		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		11,213		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		12,747		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		75,753		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,758		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		77,511		22.00
23.00	Allowable bad debts (see instructions)		572		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		372		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		572		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)		77,883		26.00
26.01	Sequestration adjustment (see instructions)		1,558		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		73,797		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)		2,528		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1326 | Component CCN: 14-3477 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-4 | Date/Time Prepared: 11/20/2023 2:29 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,398,365	1,398,365	1,398,365	1,398,365	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000756	0.002085	0.000275	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,057	2,916	385	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	22,027	4,808	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	23,084	7,724	385	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,595,877	1,595,877	1,595,877	1,595,877	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,285,160	1,285,160	1,285,160	1,285,160	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.014465	0.004840	0.000241	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	18,590	6,220	310	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	41,674	13,944	695	0	10.00
11.00	Total number of injections/infusions (from your records)	99	273	36	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	420.95	51.08	19.31	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	42	118	30	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)	17,680	6,027	579	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)		56,313	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)		24,286	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1326 | Component CCN: 14-8529 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-4 | Date/Time Prepared: 11/20/2023 2:29 pm

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	297,221	297,221	297,221	297,221	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000588	0.001654	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	175	492	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	3,560	792	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	3,735	1,284	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	315,238	315,238	315,238	315,238	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	455,865	455,865	455,865	455,865	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.011848	0.004073	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	5,401	1,857	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	9,136	3,141	0	0	10.00
11.00	Total number of injections/infusions (from your records)	16	45	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	571.00	69.80	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	1	17	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	571	1,187	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		12,277	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)		1,758	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1326 Component CCN: 14-3477	Period: From 07/01/2022 To 06/30/2023	Worksheet M-5 Date/Time Prepared: 11/20/2023 2:29 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		432,527	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		02/13/2023	1,530	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		1,530	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		434,057	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		34,455	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		468,512	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1326 Component CCN: 14-8529	Period: From 07/01/2022 To 06/30/2023	Worksheet M-5 Date/Time Prepared: 11/20/2023 2:29 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		74,134	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		02/13/2023	337	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-337	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		73,797	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		2,528	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		76,325	7.00

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