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: 14-1344	Period: From 07/01/2022 To 06/30/2023	Worksheet S Parts I-III Date/Time Prepared: 11/21/2023 10:41 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/21/2023 Time: 10:41 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LAWRENCE COUNTY MEMORIAL HOSPITAL (14-1344) 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	Shana Strange		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	Shana Strange			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	144,992	265,789	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	366,849	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		15,046		0	10.00
200.00	TOTAL	0	511,841	280,835	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: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2023 10:41 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2100 STATE STREET	PO Box:			1.00
2.00	City: LAWRENCEVILLE	State: IL	Zip Code: 62439	County: LAWRENCE	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	LAWRENCE COUNTY MEMORIAL HOSPITAL	141344	99914	1	04/01/2005	N	O	O	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	LAWRENCE COUNTY MEMORIAL HOSPITAL	14Z344	99914		04/01/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	LCMH PRIMARY CARE CLINIC	143499	99914		03/26/2009	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2022	06/30/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2023 10:41 am

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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2023 10:41 am

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2023 10:41 am

		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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2023 10:41 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	107,316	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)	Y		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: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2023 10:41 am

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/21/2023 10:41 am

			Y/N	Date	
			1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE				
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/25/2023	Y	10/25/2023	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: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/21/2023 10:41 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			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.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUCIA		GERBER		41.00
42.00	Enter the employer/company name of the cost report preparer	BLUE & CO., LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502-992-3500		LGERBER@BLUEANDCO.COM		43.00

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		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGER		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: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2023 10:41 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	14,472.00	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	14,472.00	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	14,472.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2023 10:41 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	433	48	603			1.00
2.00	HMO and other (see instructions)	0	0				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	676	0	755			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,109	48	1,358			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,109	48	1,358	0.00	137.46	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	5,161	10,287	26,908	0.00	30.23	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	167.69	27.00
28.00	Observation Bed Days		69	344			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: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2023 10:41 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	120	12	244	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	120	12	244	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1344 | Component CCN: 14-3499 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 11/21/2023 10:41 am

			RHC I	Cost
			1.00	
	Clinic Address and Identification			
1.00	Street		2111 LEXINGTON	1.00
		City	State	ZIP Code
		1.00	2.00	3.00
2.00	City, State, ZIP Code, County	LAWRENCEVILLE	IL	62439 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		LAWRENCE			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: 14-1344
Component CCN: 14-3499

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

Worksheet S-8

Date/Time Prepared:
11/21/2023 10:41 am

RHC I

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-10 | Date/Time Prepared: 11/21/2023 10:41 am

		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)	0.501864	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,763,946	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	13,808,540	6.00
7.00	Medicaid cost (line 1 times line 6)	6,930,009	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)	2,166,063	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)	2,166,063	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)	0	0	0	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	0	0	0	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)	0	0	0	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)	466,372	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	0	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	0	27.01
28.00	Non-Medicare bad debt expense (see instructions)	466,372	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	234,055	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	234,055	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,400,118	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/21/2023 10:41 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		471,078	471,078	0	471,078	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		369,565	369,565	0	369,565	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	80,405	3,367,990	3,448,395	0	3,448,395	4.00
5.01	00580	ADMINISTRATIVE AND GENERAL	137,548	2,569,434	2,706,982	0	2,706,982	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	98,277	29,469	127,746	0	127,746	5.02
5.03	01160	COMMUNICATIONS	0	76,605	76,605	0	76,605	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	950,349	2,202,506	3,152,855	0	3,152,855	5.04
6.00	00600	MAINTENANCE & REPAIRS	163,919	279,167	443,086	0	443,086	6.00
7.00	00700	OPERATION OF PLANT	0	180,695	180,695	0	180,695	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	98,729	98,729	0	98,729	8.00
9.00	00900	HOUSEKEEPING	369,529	51,240	420,769	0	420,769	9.00
10.00	01000	DIETARY	251,586	201,786	453,372	-389,889	63,483	10.00
11.00	01100	CAFETERIA	0	0	0	389,889	389,889	11.00
13.00	01300	NURSING ADMINISTRATION	211,916	13,007	224,923	0	224,923	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	234,186	204,457	438,643	0	438,643	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	227,638	45,141	272,779	0	272,779	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	183,030	183,030	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	288,279	288,279	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,385,627	105,288	1,490,915	-183,030	1,307,885	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	327,664	574,947	902,611	-12,092	890,519	50.00
53.00	05300	ANESTHESIOLOGY	281,817	34,990	316,807	-288,279	28,528	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	525,978	597,366	1,123,344	0	1,123,344	54.00
57.00	05700	CT SCAN	0	95,324	95,324	0	95,324	57.00
58.00	05800	MRI	0	180,666	180,666	0	180,666	58.00
60.00	06000	LABORATORY	633,347	498,664	1,132,011	0	1,132,011	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	35,337	35,337	0	35,337	62.00
64.00	06400	INTRAVENOUS THERAPY	67,595	19,590	87,185	0	87,185	64.00
65.00	06500	RESPIRATORY THERAPY	243,262	33,875	277,137	0	277,137	65.00
66.00	06600	PHYSICAL THERAPY	348,977	121,576	470,553	0	470,553	66.00
67.00	06700	OCCUPATIONAL THERAPY	176,699	2,037	178,736	0	178,736	67.00
68.00	06800	SPEECH PATHOLOGY	88,994	337	89,331	0	89,331	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,092	12,092	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,017,944	1,017,944	0	1,017,944	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,473,327	254,969	2,728,296	19,285	2,747,581	88.00
90.00	09000	CLINIC	491,952	503,508	995,460	0	995,460	90.00
91.00	09100	EMERGENCY	869,860	1,646,869	2,516,729	0	2,516,729	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,640,452	15,884,156	26,524,608	19,285	26,543,893	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	3,829	52,419	56,248	-19,285	36,963	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	10,644,281	15,936,575	26,580,856	0	26,580,856	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/21/2023 10:41 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	471,078		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-11,736	357,829		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	783,517	4,231,912		4.00
5.01	00580	ADMINISTRATIVE AND GENERAL	0	2,706,982		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-29,568	98,178		5.02
5.03	01160	COMMUNICATIONS	-9,342	67,263		5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	375,846	3,528,701		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	443,086		6.00
7.00	00700	OPERATION OF PLANT	227,002	407,697		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	98,729		8.00
9.00	00900	HOUSEKEEPING	110,958	531,727		9.00
10.00	01000	DIETARY	57,028	120,511		10.00
11.00	01100	CAFETERIA	-112,002	277,887		11.00
13.00	01300	NURSING ADMINISTRATION	45,066	269,989		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	166,998	605,641		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,664	271,115		16.00
17.00	01700	SOCIAL SERVICE	140,403	323,433		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	288,279		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,307,885		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	890,519		50.00
53.00	05300	ANESTHESIOLOGY	0	28,528		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,123,344		54.00
57.00	05700	CT SCAN	0	95,324		57.00
58.00	05800	MRI	0	180,666		58.00
60.00	06000	LABORATORY	-13,774	1,118,237		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	35,337		62.00
64.00	06400	INTRAVENOUS THERAPY	0	87,185		64.00
65.00	06500	RESPIRATORY THERAPY	0	277,137		65.00
66.00	06600	PHYSICAL THERAPY	0	470,553		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	178,736		67.00
68.00	06800	SPEECH PATHOLOGY	0	89,331		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,380	27,380		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,092		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-515,683	502,261		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	2,747,581		88.00
90.00	09000	CLINIC	-332,263	663,197		90.00
91.00	09100	EMERGENCY	-276,540	2,240,189		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	631,626	27,175,519		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	36,963		192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	631,626	27,212,482		200.00

RECLASSIFICATIONS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/21/2023 10:41 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	216,358	173,531		1.00
	0		216,358	173,531		
	B - RHC UTILITY RECLASS					
1.00	RURAL HEALTH CLINIC	88.00	0	19,285		1.00
	0		0	19,285		
	D - SALARIES RECLASS					
1.00	SOCIAL SERVICE	17.00	183,030	0		1.00
	0		183,030	0		
	F - CRNA RECLASS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	281,817	6,462		1.00
	0		281,817	6,462		
	G - IMPLANT DEVICE COST RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	12,092		1.00
	0		0	12,092		
500.00	Grand Total: Increases		681,205	211,370		500.00

RECLASSIFICATIONS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/21/2023 10:41 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	216,358	173,531	0		1.00
	0		216,358	173,531			
	B - RHC UTILITY RECLASS						
1.00	PHYSICIANS PRIVATE OFFICES	192.00	0	19,285	0		1.00
	0		0	19,285			
	D - SALARIES RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	183,030	0	0		1.00
	0		183,030	0			
	F - CRNA RECLASS						
1.00	ANESTHESIOLOGY	53.00	281,817	6,462	0		1.00
	0		281,817	6,462			
	G - IMPLANT DEVICE COST RECLASS						
1.00	OPERATING ROOM	50.00	0	12,092	0		1.00
	0		0	12,092			
500.00	Grand Total: Decreases		681,205	211,370			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 11/21/2023 10:41 am

		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	20,149	20,336	0	20,336	0	1.00
2.00	Land Improvements	577,873	37,698	0	37,698	0	2.00
3.00	Buildings and Fixtures	9,966,700	22,491	0	22,491	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	521,520	0	0	0	0	5.00
6.00	Movable Equipment	5,315,833	462,470	0	462,470	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,402,075	542,995	0	542,995	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	16,402,075	542,995	0	542,995	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	40,485	0	1.00
2.00	Land Improvements	615,571	0	2.00
3.00	Buildings and Fixtures	9,989,191	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	521,520	0	5.00
6.00	Movable Equipment	5,778,303	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,945,070	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	16,945,070	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 11/21/2023 10:41 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	471,078	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	369,565	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	840,643	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	471,078		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	369,565		2.00
3.00	Total (sum of lines 1-2)	0	840,643		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 11/21/2023 10:41 am

	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	11,166,767	0	11,166,767	0.658998	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,778,303	0	5,778,303	0.341002	0	2.00
3.00	Total (sum of lines 1-2)	16,945,070	0	16,945,070	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	471,078	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	369,565	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	840,643	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	471,078	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-11,736	0	0	0	357,829	2.00
3.00	Total (sum of lines 1-2)	-11,736	0	0	0	828,907	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/21/2023 10:41 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	A	-11,736	CAP REL COSTS-MVBLE EQUIP	2.00	11	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)	B	-29,568	PURCHASING RECEIVING AND STORES	5.02	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-9,342	COMMUNICATIONS	5.03	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	-622,577			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	2,745,681			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-112,002	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-1,664	MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	340B COSTS	A	-515,683	DRUGS CHARGED TO PATIENTS	73.00	0	33.00
33.01	MISC REVENUE - ADMIN	B	-15,455	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/21/2023 10:41 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	LOBBYING EXPENSE	A	-6,676	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.02
33.03	IL PROVIDER ASSESSMENT TAX	A	-646,510	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.03
33.04	ADVERTISING EXPENSE OFFSET	A	-142,842	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		631,626				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 11/21/2023 10:41 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	MANAGEMENT SERVICES	783,517	0	1.00
2.00	5.04	OTHER ADMINISTRATIVE AND GEN	MANAGEMENT SERVICES	1,187,329	0	2.00
3.00	7.00	OPERATION OF PLANT	MANAGEMENT SERVICES	227,002	0	3.00
3.01	9.00	HOUSEKEEPING	MANAGEMENT SERVICES	110,958	0	3.01
3.02	10.00	DIETARY	MANAGEMENT SERVICES	57,028	0	3.02
3.03	13.00	NURSING ADMINISTRATION	MANAGEMENT SERVICES	45,066	0	3.03
3.04	71.00	MEDICAL SUPPLIES CHARGED TO	MANAGEMENT SERVICES	27,380	0	3.04
3.05	15.00	PHARMACY	MANAGEMENT SERVICES	166,998	0	3.05
4.00	17.00	SOCIAL SERVICE	MANAGEMENT SERVICES	140,403	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,745,681	0	5.00

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

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

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

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

6.00	B		0.00	DEACONESS	0.04	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 11/21/2023 10:41 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	783,517	0		1.00
2.00	1,187,329	0		2.00
3.00	227,002	0		3.00
3.01	110,958	0		3.01
3.02	57,028	0		3.02
3.03	45,066	0		3.03
3.04	27,380	0		3.04
3.05	166,998	0		3.05
4.00	140,403	0		4.00
5.00	2,745,681			5.00

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

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

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

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

6.00	HOSPITAL		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 11/21/2023 10:41 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	13,774	13,774	0	0	0	1.00
2.00	90.00	CLINIC	332,263	332,263	0	0	0	2.00
3.00	91.00	EMERGENCY	1,494,813	276,540	1,218,273	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,840,850	622,577	1,218,273		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	90.00	CLINIC	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	13,774		1.00
2.00	90.00	CLINIC	0	0	0	332,263		2.00
3.00	91.00	EMERGENCY	0	0	0	276,540		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	622,577		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/21/2023 10:41 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE AND GENERAL	
				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	471,078	471,078				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	357,829		357,829			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,231,912	0	0	4,231,912		4.00
5.01	00580	ADMINISTRATIVE AND GENERAL	2,706,982	12,592	0	55,102	2,774,676	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	98,178	4,136	0	39,370	0	5.02
5.03	01160	COMMUNICATIONS	67,263	0	0	0	0	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	3,528,701	33,855	19,237	380,712	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	443,086	0	0	65,666	0	6.00
7.00	00700	OPERATION OF PLANT	407,697	94,050	1,956	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	98,729	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	531,727	5,404	564	148,034	0	9.00
10.00	01000	DIETARY	120,511	6,106	60	14,112	0	10.00
11.00	01100	CAFETERIA	277,887	14,181	291	86,673	0	11.00
13.00	01300	NURSING ADMINISTRATION	269,989	1,881	0	84,894	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	605,641	2,809	0	93,815	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	271,115	9,343	1,029	91,192	0	16.00
17.00	01700	SOCIAL SERVICE	323,433	298	0	73,322	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	288,279	0	0	112,896	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,307,885	75,239	26,632	481,763	62,083	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	890,519	57,523	106,400	131,263	224,701	50.00
53.00	05300	ANESTHESIOLOGY	28,528	333	17,233	0	30,155	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,123,344	7,915	124,702	210,708	289,925	54.00
57.00	05700	CT SCAN	95,324	5,029	4,369	0	303,197	57.00
58.00	05800	MRI	180,666	3,148	0	0	133,638	58.00
60.00	06000	LABORATORY	1,118,237	6,885	25,796	253,720	483,426	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	35,337	1,131	0	0	12,030	62.00
64.00	06400	INTRAVENOUS THERAPY	87,185	0	494	27,079	20,443	64.00
65.00	06500	RESPIRATORY THERAPY	277,137	6,528	5,653	97,451	49,400	65.00
66.00	06600	PHYSICAL THERAPY	470,553	9,355	3,118	139,801	128,754	66.00
67.00	06700	OCCUPATIONAL THERAPY	178,736	0	0	70,786	40,383	67.00
68.00	06800	SPEECH PATHOLOGY	89,331	0	0	35,651	9,533	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,380	3,005	0	0	39,317	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,092	0	0	0	22,861	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	502,261	0	1,447	0	207,132	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,747,581	66,425	5,151	990,823	312,012	88.00
90.00	09000	CLINIC	663,197	15,943	1,334	197,077	110,877	90.00
91.00	09100	EMERGENCY	2,240,189	14,175	10,801	348,468	294,809	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,175,519	457,289	356,267	4,230,378	2,774,676	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	36,963	13,789	1,562	1,534	0	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)	27,212,482	471,078	357,829	4,231,912	2,774,676	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/21/2023 10:41 am

		Cost Center Description	PURCHASING RECEIVING AND STORES	COMMUNICATIONS	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
		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	00580	ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	141,684					5.02
5.03	01160	COMMUNICATIONS	0	67,263				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	15,983	8,505	3,986,993	3,986,993		5.04
6.00	00600	MAINTENANCE & REPAIRS	2,188	0	510,940	87,711	598,651	6.00
7.00	00700	OPERATION OF PLANT	0	773	504,476	86,601	133,895	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	98,729	16,948	0	8.00
9.00	00900	HOUSEKEEPING	6,127	773	692,629	118,900	7,693	9.00
10.00	01000	DIETARY	255	1,933	142,977	24,544	8,693	10.00
11.00	01100	CAFETERIA	0	0	379,032	65,067	20,190	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,160	357,924	61,443	2,677	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	958	773	703,996	120,851	3,999	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	404	3,479	376,562	64,643	13,302	16.00
17.00	01700	SOCIAL SERVICE	0	0	397,053	68,160	424	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	401,175	68,868	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,420	14,303	1,973,325	338,751	107,117	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,992	6,572	1,460,970	250,797	81,894	50.00
53.00	05300	ANESTHESIOLOGY	354	387	76,990	13,216	474	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,057	2,706	1,765,357	303,050	11,268	54.00
57.00	05700	CT SCAN	1,566	0	409,485	70,294	7,159	57.00
58.00	05800	MRI	101	0	317,553	54,513	4,482	58.00
60.00	06000	LABORATORY	22,857	1,933	1,912,854	328,370	9,803	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	48,498	8,325	1,610	62.00
64.00	06400	INTRAVENOUS THERAPY	2,097	0	137,298	23,569	0	64.00
65.00	06500	RESPIRATORY THERAPY	971	1,546	438,686	75,307	9,294	65.00
66.00	06600	PHYSICAL THERAPY	2,819	1,546	755,946	129,769	13,319	66.00
67.00	06700	OCCUPATIONAL THERAPY	244	0	290,149	49,808	0	67.00
68.00	06800	SPEECH PATHOLOGY	40	0	134,555	23,098	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	69,702	11,965	4,279	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	34,953	6,000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	710,840	122,026	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	15,390	13,916	4,151,298	712,625	94,569	88.00
90.00	09000	CLINIC	7,532	3,479	999,439	171,569	22,698	90.00
91.00	09100	EMERGENCY	6,329	3,479	2,918,250	500,961	20,181	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	141,684	67,263	27,158,634	3,977,749	579,020	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	53,848	9,244	19,631	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)	141,684	67,263	27,212,482	3,986,993	598,651	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/21/2023 10:41 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	01160	COMMUNICATIONS						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	724,972					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	115,677				8.00
9.00	00900	HOUSEKEEPING	15,910	0	835,132			9.00
10.00	01000	DIETARY	17,977	4,183	74,742	273,116		10.00
11.00	01100	CAFETERIA	41,754	0	0	0	506,043	11.00
13.00	01300	NURSING ADMINISTRATION	5,537	0	12,444	0	11,378	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	8,270	0	4,978	0	11,161	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,509	0	20,137	0	29,203	16.00
17.00	01700	SOCIAL SERVICE	876	0	0	0	13,870	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	221,526	45,535	162,908	273,116	120,118	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	169,363	11,235	104,457	0	29,095	50.00
53.00	05300	ANESTHESIOLOGY	981	0	0	0	6,014	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,304	11,663	41,406	0	50,875	54.00
57.00	05700	CT SCAN	14,806	5,192	0	0	0	57.00
58.00	05800	MRI	9,269	0	0	0	0	58.00
60.00	06000	LABORATORY	20,272	636	38,238	0	64,745	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,329	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	5,147	64.00
65.00	06500	RESPIRATORY THERAPY	19,221	269	8,673	0	19,234	65.00
66.00	06600	PHYSICAL THERAPY	27,544	4,389	38,615	0	29,528	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	10,836	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	4,389	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,848	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	46,940	4,378	34,090	0	28,336	90.00
91.00	09100	EMERGENCY	41,736	28,197	84,697	0	72,114	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	724,972	115,677	625,385	273,116	506,043	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	209,747	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)	724,972	115,677	835,132	273,116	506,043	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/21/2023 10:41 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	01160	COMMUNICATIONS						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	451,403					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0				14.00
15.00	01500	PHARMACY	0	0	853,255			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	531,356		16.00
17.00	01700	SOCIAL SERVICE	23,202	0	0	0	503,585	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	200,911	0	0	323,722	503,585	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	48,666	0	0	95,525	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
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	8,601	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	19,238	0	65.00
66.00	06600	PHYSICAL THERAPY	49,359	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	853,255	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	92,871	0	90.00
91.00	09100	EMERGENCY	120,664	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	451,403	0	853,255	531,356	503,585	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	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)	451,403	0	853,255	531,356	503,585	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/21/2023 10:41 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	01160	COMMUNICATIONS						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	470,043					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,270,614	0	4,270,614		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,252,002	0	2,252,002		50.00
53.00	05300	ANESTHESIOLOGY	470,043	567,718	0	567,718		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,206,923	0	2,206,923		54.00
57.00	05700	CT SCAN	0	506,936	0	506,936		57.00
58.00	05800	MRI	0	385,817	0	385,817		58.00
60.00	06000	LABORATORY	0	2,374,918	0	2,374,918		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	61,762	0	61,762		62.00
64.00	06400	INTRAVENOUS THERAPY	0	174,615	0	174,615		64.00
65.00	06500	RESPIRATORY THERAPY	0	589,922	0	589,922		65.00
66.00	06600	PHYSICAL THERAPY	0	1,048,469	0	1,048,469		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	350,793	0	350,793		67.00
68.00	06800	SPEECH PATHOLOGY	0	162,042	0	162,042		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	94,794	0	94,794		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	40,953	0	40,953		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,686,121	0	1,686,121		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,958,492	0	4,958,492		88.00
90.00	09000	CLINIC	0	1,400,321	0	1,400,321		90.00
91.00	09100	EMERGENCY	0	3,786,800	0	3,786,800		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	470,043	26,920,012	0	26,920,012		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	292,470	0	292,470		192.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	470,043	27,212,482	0	27,212,482		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/21/2023 10:41 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00580	ADMINISTRATIVE AND GENERAL	0	12,592	0	12,592	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	4,136	0	4,136	0	5.02
5.03	01160	COMMUNICATIONS	0	0	0	0	0	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	33,855	19,237	53,092	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	94,050	1,956	96,006	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	5,404	564	5,968	0	9.00
10.00	01000	DIETARY	0	6,106	60	6,166	0	10.00
11.00	01100	CAFETERIA	0	14,181	291	14,472	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,881	0	1,881	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	2,809	0	2,809	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,343	1,029	10,372	0	16.00
17.00	01700	SOCIAL SERVICE	0	298	0	298	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	75,239	26,632	101,871	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	57,523	106,400	163,923	0	50.00
53.00	05300	ANESTHESIOLOGY	0	333	17,233	17,566	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,915	124,702	132,617	0	54.00
57.00	05700	CT SCAN	0	5,029	4,369	9,398	0	57.00
58.00	05800	MRI	0	3,148	0	3,148	0	58.00
60.00	06000	LABORATORY	0	6,885	25,796	32,681	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,131	0	1,131	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	494	494	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,528	5,653	12,181	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,355	3,118	12,473	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,005	0	3,005	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,447	1,447	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	66,425	5,151	71,576	0	88.00
90.00	09000	CLINIC	0	15,943	1,334	17,277	0	90.00
91.00	09100	EMERGENCY	0	14,175	10,801	24,976	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	457,289	356,267	813,556	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	13,789	1,562	15,351	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	471,078	357,829	828,907	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/21/2023 10:41 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL	PURCHASING RECEIVING AND STORES	COMMUNICATIONS	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.01	5.02	5.03	5.04	6.00	
		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	00580	ADMINISTRATIVE AND GENERAL	12,592					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	4,136				5.02
5.03	01160	COMMUNICATIONS	0	0	0			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	467	0	53,559		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	64	0	1,178	1,242	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	1,163	278	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	228	0	8.00
9.00	00900	HOUSEKEEPING	0	179	0	1,597	16	9.00
10.00	01000	DIETARY	0	7	0	330	18	10.00
11.00	01100	CAFETERIA	0	0	0	874	42	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	825	6	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	28	0	1,623	8	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12	0	868	28	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	916	1	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	925	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	282	158	0	4,550	222	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,021	1,285	0	3,369	170	50.00
53.00	05300	ANESTHESIOLOGY	137	10	0	178	1	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,317	177	0	4,071	23	54.00
57.00	05700	CT SCAN	1,377	46	0	944	15	57.00
58.00	05800	MRI	607	3	0	732	9	58.00
60.00	06000	LABORATORY	2,184	667	0	4,411	20	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	55	0	0	112	3	62.00
64.00	06400	INTRAVENOUS THERAPY	93	61	0	317	0	64.00
65.00	06500	RESPIRATORY THERAPY	224	28	0	1,012	19	65.00
66.00	06600	PHYSICAL THERAPY	585	82	0	1,743	28	66.00
67.00	06700	OCCUPATIONAL THERAPY	183	7	0	669	0	67.00
68.00	06800	SPEECH PATHOLOGY	43	1	0	310	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	179	0	0	161	9	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	104	0	0	81	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	941	0	0	1,639	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,417	449	0	9,575	196	88.00
90.00	09000	CLINIC	504	220	0	2,305	47	90.00
91.00	09100	EMERGENCY	1,339	185	0	6,729	42	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,592	4,136	0	53,435	1,201	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	124	41	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)	12,592	4,136	0	53,559	1,242	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/21/2023 10:41 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	01160	COMMUNICATIONS						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	97,447					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	228				8.00
9.00	00900	HOUSEKEEPING	2,138	0	9,898			9.00
10.00	01000	DIETARY	2,416	8	886	9,831		10.00
11.00	01100	CAFETERIA	5,612	0	0	0	21,000	11.00
13.00	01300	NURSING ADMINISTRATION	744	0	147	0	472	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,112	0	59	0	463	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,698	0	239	0	1,212	16.00
17.00	01700	SOCIAL SERVICE	118	0	0	0	576	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,778	89	1,931	9,831	4,984	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,765	22	1,238	0	1,207	50.00
53.00	05300	ANESTHESIOLOGY	132	0	0	0	250	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,132	23	491	0	2,111	54.00
57.00	05700	CT SCAN	1,990	10	0	0	0	57.00
58.00	05800	MRI	1,246	0	0	0	0	58.00
60.00	06000	LABORATORY	2,725	1	453	0	2,687	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	447	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	214	64.00
65.00	06500	RESPIRATORY THERAPY	2,584	1	103	0	798	65.00
66.00	06600	PHYSICAL THERAPY	3,702	9	458	0	1,225	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	450	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	182	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,189	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	6,309	9	404	0	1,176	90.00
91.00	09100	EMERGENCY	5,610	56	1,004	0	2,993	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	97,447	228	7,413	9,831	21,000	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	2,485	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)	97,447	228	9,898	9,831	21,000	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/21/2023 10:41 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	01160	COMMUNICATIONS						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	4,075					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0				14.00
15.00	01500	PHARMACY	0	0	6,102			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	16,429		16.00
17.00	01700	SOCIAL SERVICE	209	0	0	0	2,118	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,814	0	0	10,009	2,118	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	439	0	0	2,954	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
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	78	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	595	0	65.00
66.00	06600	PHYSICAL THERAPY	446	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	6,102	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	2,871	0	90.00
91.00	09100	EMERGENCY	1,089	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,075	0	6,102	16,429	2,118	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	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)	4,075	0	6,102	16,429	2,118	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/21/2023 10:41 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	01160	COMMUNICATIONS						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	925					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		167,637	0	167,637		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		198,393	0	198,393		50.00
53.00	05300	ANESTHESIOLOGY		18,274	0	18,274		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		143,962	0	143,962		54.00
57.00	05700	CT SCAN		13,780	0	13,780		57.00
58.00	05800	MRI		5,745	0	5,745		58.00
60.00	06000	LABORATORY		45,829	0	45,829		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		1,748	0	1,748		62.00
64.00	06400	INTRAVENOUS THERAPY		1,257	0	1,257		64.00
65.00	06500	RESPIRATORY THERAPY		17,545	0	17,545		65.00
66.00	06600	PHYSICAL THERAPY		20,751	0	20,751		66.00
67.00	06700	OCCUPATIONAL THERAPY		1,309	0	1,309		67.00
68.00	06800	SPEECH PATHOLOGY		536	0	536		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		4,543	0	4,543		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		185	0	185		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		10,129	0	10,129		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		83,213	0	83,213		88.00
90.00	09000	CLINIC		31,122	0	31,122		90.00
91.00	09100	EMERGENCY		44,023	0	44,023		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM		0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	809,981	0	809,981		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES		18,001	0	18,001		192.00
200.00		Cross Foot Adjustments	925	925	0	925		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	925	828,907	0	828,907		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/21/2023 10:41 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMINISTRATIVE AND GENERAL (GROSS CHARGES)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	79,159					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		369,567				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	10,563,876			4.00
5.01	00580	ADMINISTRATIVE AND GENERAL	2,116	0	137,548	53,640,064		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	695	0	98,277	0	1,183,596	5.02
5.03	01160	COMMUNICATIONS	0	0	0	0	0	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	5,689	19,868	950,349	0	133,518	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	163,919	0	18,282	6.00
7.00	00700	OPERATION OF PLANT	15,804	2,020	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	908	583	369,529	0	51,186	9.00
10.00	01000	DIETARY	1,026	62	35,228	0	2,130	10.00
11.00	01100	CAFETERIA	2,383	301	216,358	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	316	0	211,916	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	472	0	234,186	0	8,005	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,570	1,063	227,638	0	3,376	16.00
17.00	01700	SOCIAL SERVICE	50	0	183,030	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	281,817	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,643	27,506	1,202,597	1,200,181	45,274	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,666	109,890	327,664	4,343,893	367,491	50.00
53.00	05300	ANESTHESIOLOGY	56	17,798	0	582,944	2,957	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,330	128,794	525,978	5,604,800	50,595	54.00
57.00	05700	CT SCAN	845	4,512	0	5,861,376	13,080	57.00
58.00	05800	MRI	529	0	0	2,583,483	845	58.00
60.00	06000	LABORATORY	1,157	26,642	633,347	9,345,866	190,944	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	190	0	0	232,568	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	510	67,595	395,195	17,522	64.00
65.00	06500	RESPIRATORY THERAPY	1,097	5,838	243,262	955,003	8,114	65.00
66.00	06600	PHYSICAL THERAPY	1,572	3,220	348,977	2,489,051	23,550	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	176,699	780,671	2,037	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	88,994	184,287	337	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	505	0	0	760,070	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	441,955	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,494	0	4,004,247	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	11,162	5,320	2,473,327	6,031,786	128,562	88.00
90.00	09000	CLINIC	2,679	1,378	491,952	2,143,466	62,917	90.00
91.00	09100	EMERGENCY	2,382	11,155	869,860	5,699,222	52,874	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,842	367,954	10,560,047	53,640,064	1,183,596	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,317	1,613	3,829	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)	471,078	357,829	4,231,912	2,774,676	141,684	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.951035	0.968239	0.400602	0.051728	0.119706	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	12,592	4,136	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000235	0.003494	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: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/21/2023 10:41 am

		Cost Center Description	COMMUNICATIONS (PHONES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5A.04	5.04	6.00	7.00	
		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	00580	ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	01160	COMMUNICATIONS	174					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	22	-3,986,993	23,225,489			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	510,940	70,659		6.00
7.00	00700	OPERATION OF PLANT	2	0	504,476	15,804	41,376	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	98,729	0	0	8.00
9.00	00900	HOUSEKEEPING	2	0	692,629	908	908	9.00
10.00	01000	DIETARY	5	0	142,977	1,026	1,026	10.00
11.00	01100	CAFETERIA	0	0	379,032	2,383	2,383	11.00
13.00	01300	NURSING ADMINISTRATION	3	0	357,924	316	316	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	2	0	703,996	472	472	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9	0	376,562	1,570	1,570	16.00
17.00	01700	SOCIAL SERVICE	0	0	397,053	50	50	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	401,175	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37	0	1,973,325	12,643	12,643	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17	0	1,460,970	9,666	9,666	50.00
53.00	05300	ANESTHESIOLOGY	1	0	76,990	56	56	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7	0	1,765,357	1,330	1,330	54.00
57.00	05700	CT SCAN	0	0	409,485	845	845	57.00
58.00	05800	MRI	0	0	317,553	529	529	58.00
60.00	06000	LABORATORY	5	0	1,912,854	1,157	1,157	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	48,498	190	190	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	137,298	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4	0	438,686	1,097	1,097	65.00
66.00	06600	PHYSICAL THERAPY	4	0	755,946	1,572	1,572	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	290,149	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	134,555	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	69,702	505	505	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	34,953	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	710,840	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	36	0	4,151,298	11,162	0	88.00
90.00	09000	CLINIC	9	0	999,439	2,679	2,679	90.00
91.00	09100	EMERGENCY	9	0	2,918,250	2,382	2,382	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	174	-3,986,993	23,171,641	68,342	41,376	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	53,848	2,317	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)	67,263		3,986,993	598,651	724,972	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	386.568966		0.171665	8.472396	17.521558	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		53,559	1,242	97,447	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.002306	0.017577	2.355158	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: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/21/2023 10:41 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	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	00580	ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	01160	COMMUNICATIONS						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	66,977					8.00
9.00	00900	HOUSEKEEPING	0	11,073				9.00
10.00	01000	DIETARY	2,422	991	6,701			10.00
11.00	01100	CAFETERIA	0	0	0	9,340		11.00
13.00	01300	NURSING ADMINISTRATION	0	165	0	210	103,599	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	66	0	206	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	267	0	539	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	256	5,325	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,365	2,160	6,701	2,217	46,110	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,505	1,385	0	537	11,169	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	111	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,753	549	0	939	0	54.00
57.00	05700	CT SCAN	3,006	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	368	507	0	1,195	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	95	1,974	64.00
65.00	06500	RESPIRATORY THERAPY	156	115	0	355	0	65.00
66.00	06600	PHYSICAL THERAPY	2,541	512	0	545	11,328	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	200	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	81	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	2,535	452	0	523	0	90.00
91.00	09100	EMERGENCY	16,326	1,123	0	1,331	27,693	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,977	8,292	6,701	9,340	103,599	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	2,781	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)	115,677	835,132	273,116	506,043	451,403	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.727115	75.420573	40.757499	54.180193	4.357214	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	228	9,898	9,831	21,000	4,075	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003404	0.893886	1.467094	2.248394	0.039334	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: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/21/2023 10:41 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			14.00	15.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	01160	COMMUNICATIONS						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0					14.00
15.00	01500	PHARMACY	0	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	801			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	100		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	488	100	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	144	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	29	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	140	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	100	801	100	100	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	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)	0	853,255	531,356	503,585	470,043	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	8,532.550000	663.365793	5,035.850000	4,700.430000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	6,102	16,429	2,118	925	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	61.020000	20.510612	21.180000	9.250000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/21/2023 10:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,270,614		4,270,614	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,252,002		2,252,002	0	0	50.00
53.00	05300	ANESTHESIOLOGY	567,718		567,718	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,206,923		2,206,923	0	0	54.00
57.00	05700	CT SCAN	506,936		506,936	0	0	57.00
58.00	05800	MRI	385,817		385,817	0	0	58.00
60.00	06000	LABORATORY	2,374,918		2,374,918	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	61,762		61,762	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	174,615		174,615	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	589,922	0	589,922	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,048,469	0	1,048,469	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	350,793	0	350,793	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	162,042	0	162,042	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	94,794		94,794	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,953		40,953	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,686,121		1,686,121	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,958,492		4,958,492	0	0	88.00
90.00	09000	CLINIC	1,400,321		1,400,321	0	0	90.00
91.00	09100	EMERGENCY	3,786,800		3,786,800	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	863,158		863,158		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	27,783,170	0	27,783,170	0	0	200.00
201.00		Less Observation Beds	863,158		863,158		0	201.00
202.00		Total (see instructions)	26,920,012	0	26,920,012	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I | Date/Time Prepared: 11/21/2023 10:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	930,763		930,763			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,538	4,289,355	4,343,893	0.518429	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	12,062	570,882	582,944	0.973881	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	157,837	5,446,963	5,604,800	0.393756	0.000000	54.00
57.00	05700	CT SCAN	142,391	5,718,985	5,861,376	0.086488	0.000000	57.00
58.00	05800	MRI	54,137	2,529,346	2,583,483	0.149340	0.000000	58.00
60.00	06000	LABORATORY	427,695	8,918,171	9,345,866	0.254114	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	48,434	184,134	232,568	0.265565	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	680	394,515	395,195	0.441845	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	325,768	629,235	955,003	0.617717	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	307,448	2,181,603	2,489,051	0.421232	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	147,477	633,194	780,671	0.449348	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	21,407	162,880	184,287	0.879292	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	509,600	250,470	760,070	0.124717	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	441,955	441,955	0.092663	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	977,622	3,026,625	4,004,247	0.421083	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	91,257	5,940,529	6,031,786			88.00
90.00	09000	CLINIC	18,692	2,124,774	2,143,466	0.653298	0.000000	90.00
91.00	09100	EMERGENCY	406	5,698,816	5,699,222	0.664442	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,086	261,332	269,418	3.203787	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	4,236,300	49,403,764	53,640,064			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,236,300	49,403,764	53,640,064			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/21/2023 10:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/21/2023 10:41 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,270,614		4,270,614	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,252,002		2,252,002	0	0	50.00
53.00	05300	ANESTHESIOLOGY	567,718		567,718	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,206,923		2,206,923	0	0	54.00
57.00	05700	CT SCAN	506,936		506,936	0	0	57.00
58.00	05800	MRI	385,817		385,817	0	0	58.00
60.00	06000	LABORATORY	2,374,918		2,374,918	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	61,762		61,762	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	174,615		174,615	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	589,922	0	589,922	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,048,469	0	1,048,469	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	350,793	0	350,793	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	162,042	0	162,042	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	94,794		94,794	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,953		40,953	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,686,121		1,686,121	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,958,492		4,958,492	0	0	88.00
90.00	09000	CLINIC	1,400,321		1,400,321	0	0	90.00
91.00	09100	EMERGENCY	3,786,800		3,786,800	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	863,158		863,158		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	27,783,170	0	27,783,170	0	0	200.00
201.00		Less Observation Beds	863,158		863,158		0	201.00
202.00		Total (see instructions)	26,920,012	0	26,920,012	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I | Date/Time Prepared: 11/21/2023 10:41 am

Title XIX | 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	930,763		930,763			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,538	4,289,355	4,343,893	0.518429	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	12,062	570,882	582,944	0.973881	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	157,837	5,446,963	5,604,800	0.393756	0.000000	54.00
57.00	05700	CT SCAN	142,391	5,718,985	5,861,376	0.086488	0.000000	57.00
58.00	05800	MRI	54,137	2,529,346	2,583,483	0.149340	0.000000	58.00
60.00	06000	LABORATORY	427,695	8,918,171	9,345,866	0.254114	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	48,434	184,134	232,568	0.265565	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	680	394,515	395,195	0.441845	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	325,768	629,235	955,003	0.617717	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	307,448	2,181,603	2,489,051	0.421232	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	147,477	633,194	780,671	0.449348	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	21,407	162,880	184,287	0.879292	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	509,600	250,470	760,070	0.124717	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	441,955	441,955	0.092663	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	977,622	3,026,625	4,004,247	0.421083	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	91,257	5,940,529	6,031,786	0.822060	0.000000	88.00
90.00	09000	CLINIC	18,692	2,124,774	2,143,466	0.653298	0.000000	90.00
91.00	09100	EMERGENCY	406	5,698,816	5,699,222	0.664442	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,086	261,332	269,418	3.203787	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	4,236,300	49,403,764	53,640,064			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,236,300	49,403,764	53,640,064			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I | Date/Time Prepared: 11/21/2023 10:41 am

Title XIX | 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
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
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: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 11/21/2023 10:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	198,393	4,343,893	0.045672	14,110	644	50.00
53.00	05300	ANESTHESIOLOGY	18,274	582,944	0.031348	442	14	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	143,962	5,604,800	0.025685	67,166	1,725	54.00
57.00	05700	CT SCAN	13,780	5,861,376	0.002351	70,707	166	57.00
58.00	05800	MRI	5,745	2,583,483	0.002224	45,071	100	58.00
60.00	06000	LABORATORY	45,829	9,345,866	0.004904	234,214	1,149	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,748	232,568	0.007516	18,218	137	62.00
64.00	06400	INTRAVENOUS THERAPY	1,257	395,195	0.003181	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	17,545	955,003	0.018372	163,968	3,012	65.00
66.00	06600	PHYSICAL THERAPY	20,751	2,489,051	0.008337	34,965	292	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,309	780,671	0.001677	15,614	26	67.00
68.00	06800	SPEECH PATHOLOGY	536	184,287	0.002909	9,116	27	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,543	760,070	0.005977	195,132	1,166	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	185	441,955	0.000419	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,129	4,004,247	0.002530	401,450	1,016	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	83,213	6,031,786	0.013796	0	0	88.00
90.00	09000	CLINIC	31,122	2,143,466	0.014519	0	0	90.00
91.00	09100	EMERGENCY	44,023	5,699,222	0.007724	160	1	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	33,882	269,418	0.125760	1,161	146	92.00
200.00		Total (lines 50 through 199)	676,226	52,709,301		1,271,494	9,621	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/21/2023 10:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	470,043	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	470,043	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/21/2023 10:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	4,343,893	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	470,043	0	582,944	0.806326	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,604,800	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	5,861,376	0.000000	57.00
58.00	05800	MRI	0	0	0	2,583,483	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	9,345,866	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	232,568	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	395,195	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	955,003	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,489,051	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	780,671	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	184,287	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	760,070	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	441,955	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,004,247	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	6,031,786	0.000000	88.00
90.00	09000	CLINIC	0	0	0	2,143,466	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	5,699,222	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	269,418	0.000000	92.00
200.00		Total (lines 50 through 199)	0	470,043	0	52,709,301		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/21/2023 10:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	14,110	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	442	356	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	67,166	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	70,707	0	0	0	57.00
58.00	05800	MRI	0.000000	45,071	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	234,214	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	18,218	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	163,968	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	34,965	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	15,614	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	9,116	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	195,132	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	401,450	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	160	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,161	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,271,494	356	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/21/2023 10:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.518429	0	1,312,930	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.973881	0	180,003	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.393756	0	2,853,377	0	0	54.00
57.00	05700	CT SCAN	0.086488	0	1,795,273	0	0	57.00
58.00	05800	MRI	0.149340	0	831,815	0	0	58.00
60.00	06000	LABORATORY	0.254114	0	2,945,596	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.265565	0	89,392	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.441845	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.617717	0	339,602	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.421232	0	842,392	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.449348	0	124,799	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.879292	0	30,535	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.124717	0	77,693	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.092663	0	168,465	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.421083	0	30,653	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0.653298	0	409,821	0	0	90.00
91.00	09100	EMERGENCY	0.664442	0	1,610,461	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3.203787	0	129,340	0	0	92.00
200.00		Subtotal (see instructions)		0	13,772,147	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	13,772,147	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/21/2023 10:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	680,661	0		50.00
53.00	05300	ANESTHESIOLOGY	175,302	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,123,534	0		54.00
57.00	05700	CT SCAN	155,270	0		57.00
58.00	05800	MRI	124,223	0		58.00
60.00	06000	LABORATORY	748,517	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	23,739	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	209,778	0		65.00
66.00	06600	PHYSICAL THERAPY	354,842	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	56,078	0		67.00
68.00	06800	SPEECH PATHOLOGY	26,849	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,690	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,610	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,907	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	267,735	0		90.00
91.00	09100	EMERGENCY	1,070,058	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	414,378	0		92.00
200.00		Subtotal (see instructions)	5,469,171	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,469,171	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part I Date/Time Prepared: 11/21/2023 10:41 am

Title XIX | Hospital | Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	167,637	74,363	93,274	947	98.49	30.00
200.00	Total (lines 30 through 199)	167,637		93,274	947		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	48	4,728	30.00
200.00	Total (lines 30 through 199)	48	4,728	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 11/21/2023 10:41 am

Title XIX | 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	198,393	4,343,893	0.045672	0	0	50.00
53.00	05300	ANESTHESIOLOGY	18,274	582,944	0.031348	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	143,962	5,604,800	0.025685	0	0	54.00
57.00	05700	CT SCAN	13,780	5,861,376	0.002351	0	0	57.00
58.00	05800	MRI	5,745	2,583,483	0.002224	0	0	58.00
60.00	06000	LABORATORY	45,829	9,345,866	0.004904	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,748	232,568	0.007516	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1,257	395,195	0.003181	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	17,545	955,003	0.018372	0	0	65.00
66.00	06600	PHYSICAL THERAPY	20,751	2,489,051	0.008337	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,309	780,671	0.001677	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	536	184,287	0.002909	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,543	760,070	0.005977	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	185	441,955	0.000419	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,129	4,004,247	0.002530	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	83,213	6,031,786	0.013796	0	0	88.00
90.00	09000	CLINIC	31,122	2,143,466	0.014519	0	0	90.00
91.00	09100	EMERGENCY	44,023	5,699,222	0.007724	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	33,882	269,418	0.125760	0	0	92.00
200.00		Total (lines 50 through 199)	676,226	52,709,301		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part III Date/Time Prepared: 11/21/2023 10:41 am

Title XIX | Hospital | Cost

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	947	0.00	48	30.00
200.00		Total (lines 30 through 199)		0	947		48	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/21/2023 10:41 am

Title XIX | 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	470,043	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	470,043	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/21/2023 10:41 am

Title XIX | 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	4,343,893	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	470,043	0	582,944	0.806326	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,604,800	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	5,861,376	0.000000	57.00
58.00	05800	MRI	0	0	0	2,583,483	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	9,345,866	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	232,568	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	395,195	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	955,003	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,489,051	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	780,671	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	184,287	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	760,070	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	441,955	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,004,247	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	6,031,786	0.000000	88.00
90.00	09000	CLINIC	0	0	0	2,143,466	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	5,699,222	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	269,418	0.000000	92.00
200.00		Total (lines 50 through 199)	0	470,043	0	52,709,301		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/21/2023 10:41 am

Title XIX | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/21/2023 10:41 am

Title XVIII | Hospital | Cost

	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS			
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,702	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		947	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	do	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		603	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		755	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)		0	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)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		433	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)		401	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)		275	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
	SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		201.73	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)		4,270,614	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	5	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	x	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	x	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	x	0	25.00
26.00	Total swing-bed cost (see instructions)		1,894,423	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,376,191	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line minus line 36)	27	2,376,191	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		2,509.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,086,471	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,086,471	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/21/2023 10:41 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	439,645	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)	1,526,116	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)	1,006,177	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	690,022	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	1,696,199	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)	344	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,509.18	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	863,158	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/21/2023 10:41 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	167,637	4,270,614	0.039254	863,158	33,882	90.00
91.00	Nursing Program cost	0	4,270,614	0.000000	863,158	0	91.00
92.00	Allied health cost	0	4,270,614	0.000000	863,158	0	92.00
93.00	All other Medical Education	0	4,270,614	0.000000	863,158	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/21/2023 10:41 am

Title XIX | 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)		1,702	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		947	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	do	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		603	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		755	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)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		48	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
	SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		201.73	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)		4,270,614	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	5	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	x	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	x	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	x	0	25.00
26.00	Total swing-bed cost (see instructions)		1,894,423	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,376,191	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line minus line 36)	27	2,376,191	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		2,509.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		120,440	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)		120,440	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/21/2023 10:41 am

Title XIX | 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)	0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	120,440	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	344	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,509.18	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	863,158	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/21/2023 10:41 am

Title XIX | 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	167,637	4,270,614	0.039254	863,158	33,882	90.00
91.00	Nursing Program cost	0	4,270,614	0.000000	863,158	0	91.00
92.00	Allied health cost	0	4,270,614	0.000000	863,158	0	92.00
93.00	All other Medical Education	0	4,270,614	0.000000	863,158	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/21/2023 10:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		414,230		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.518429	14,110	7,315	50.00
53.00	05300	ANESTHESIOLOGY	0.973881	442	430	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.393756	67,166	26,447	54.00
57.00	05700	CT SCAN	0.086488	70,707	6,115	57.00
58.00	05800	MRI	0.149340	45,071	6,731	58.00
60.00	06000	LABORATORY	0.254114	234,214	59,517	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.265565	18,218	4,838	62.00
64.00	06400	INTRAVENOUS THERAPY	0.441845	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.617717	163,968	101,286	65.00
66.00	06600	PHYSICAL THERAPY	0.421232	34,965	14,728	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.449348	15,614	7,016	67.00
68.00	06800	SPEECH PATHOLOGY	0.879292	9,116	8,016	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.124717	195,132	24,336	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.092663	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.421083	401,450	169,044	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.653298	0	0	90.00
91.00	09100	EMERGENCY	0.664442	160	106	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3.203787	1,161	3,720	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,271,494	439,645	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)		1,271,494		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1344 | Component CCN: 14-Z344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/21/2023 10:41 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.518429	3,165	1,641	50.00
53.00	05300	ANESTHESIOLOGY	0.973881	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.393756	23,219	9,143	54.00
57.00	05700	CT SCAN	0.086488	22,479	1,944	57.00
58.00	05800	MRI	0.149340	0	0	58.00
60.00	06000	LABORATORY	0.254114	104,451	26,542	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.265565	9,789	2,600	62.00
64.00	06400	INTRAVENOUS THERAPY	0.441845	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.617717	144,169	89,056	65.00
66.00	06600	PHYSICAL THERAPY	0.421232	235,044	99,008	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.449348	110,632	49,712	67.00
68.00	06800	SPEECH PATHOLOGY	0.879292	11,415	10,037	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.124717	256,527	31,993	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.092663	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.421083	344,789	145,185	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.653298	0	0	90.00
91.00	09100	EMERGENCY	0.664442	246	163	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3.203787	977	3,130	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,266,902	470,154	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)		1,266,902		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E Part B Date/Time Prepared: 11/21/2023 10:41 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,469,171	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,469,171	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	5,523,863	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)	46,308	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,111,539	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)	3,366,016	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)	3,366,016	30.00
31.00	Primary payer payments	609	31.00
32.00	Subtotal (line 30 minus line 31)	3,365,407	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	3,365,407	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,365,407	40.00
40.01	Sequestration adjustment (see instructions)	67,308	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,032,310	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)	265,789	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: 14-1344	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/21/2023 10:41 am
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2023 10:41 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,230,042		3,032,310	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		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,230,042		3,032,310	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		144,992		265,789	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,375,034		3,298,099	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: 14-1344 | Component CCN: 14-Z344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2023 10:41 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,748,116		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		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,748,116		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		366,849		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,114,965		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: 14-1344	Period: From 07/01/2022 To 06/30/2023	Worksheet E-1 Part II Date/Time Prepared: 11/21/2023 10:41 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1344 | Component CCN: 14-Z344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-2 | Date/Time Prepared: 11/21/2023 10:41 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,713,161	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)	474,856	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	676	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)	2,188,017	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,188,017	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)	2,188,017	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	29,889	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	2,158,128	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,158,128	0	19.00
19.01	Sequestration adjustment (see instructions)	43,163	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	1,748,116	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)	366,849	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: 14-1344	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part V Date/Time Prepared: 11/21/2023 10:41 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,526,116	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)	1,526,116	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,541,377	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)	1,541,377	19.00
20.00	Deductibles (exclude professional component)	138,281	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,403,096	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,403,096	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	0	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,403,096	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)	1,403,096	30.00
30.01	Sequestration adjustment (see instructions)	28,062	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,230,042	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)	144,992	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1344	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 11/21/2023 10:41 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	120,440		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	120,440	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	120,440	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	120,440	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	120,440	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	120,440	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	120,440	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	120,440	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	120,440	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	120,440	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	120,440	0	40.00
41.00	Interim payments	120,440	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G | Date/Time Prepared: 11/21/2023 10:41 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,487,283	0	0	0	1.00
2.00	Temporary investments	1,103,401	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	12,170,953	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,547,677	0	0	0	6.00
7.00	Inventory	400,653	0	0	0	7.00
8.00	Prepaid expenses	196,772	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	12,811,385	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	40,485	0	0	0	12.00
13.00	Land improvements	615,571	0	0	0	13.00
14.00	Accumulated depreciation	-488,371	0	0	0	14.00
15.00	Buildings	9,989,191	0	0	0	15.00
16.00	Accumulated depreciation	-6,350,319	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	521,520	0	0	0	19.00
20.00	Accumulated depreciation	-399,666	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	5,778,303	0	0	0	23.00
24.00	Accumulated depreciation	-4,661,992	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	4,008,945	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	9,053,667	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	21,865,052	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,238,620	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,759,011	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	1,498,081	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	1,077,128	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,572,840	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	129,613	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)	129,613	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,702,453	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	16,162,599				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)	16,162,599	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	21,865,052	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-1 | Date/Time Prepared: 11/21/2023 10:41 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		15,094,375		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,068,634				2.00
3.00	Total (sum of line 1 and line 2)		16,163,009		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		16,163,009		0		11.00
12.00	ROUNDING	410		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)		410		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		16,162,599		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	ROUNDING		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: 14-1344 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/21/2023 10:41 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,012,226		1,012,226	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,012,226		1,012,226	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)	1,012,226		1,012,226	17.00
18.00	Ancillary services	3,135,663	45,117,782	48,253,445	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	91,257	5,940,529	6,031,786	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,239,146	51,058,311	55,297,457	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,580,856		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)		26,580,856		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1344	Period: From 07/01/2022 To 06/30/2023	Worksheet G-3 Date/Time Prepared: 11/21/2023 10:41 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	55,297,457	1.00
2.00	Less contractual allowances and discounts on patients' accounts	30,387,128	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,910,329	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,580,856	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,670,527	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	3,558	6.00
7.00	Income from investments	29,050	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	112,002	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	1,664	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	2,082,330	24.00
24.50	COVID-19 PHE Funding	510,557	24.50
25.00	Total other income (sum of lines 6-24)	2,739,161	25.00
26.00	Total (line 5 plus line 25)	1,068,634	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,068,634	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1344 | Component CCN: 14-3499 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/21/2023 10:41 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	2,473,327	0	2,473,327	-1,559,646	913,681	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	1,463,080	1,463,080	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	96,566	96,566	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)	2,473,327	0	2,473,327	0	2,473,327	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	89,833	89,833	0	89,833	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	89,833	89,833	0	89,833	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,473,327	89,833	2,563,160	0	2,563,160	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	0	0	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	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	9,184	9,184	19,285	28,469	29.00
30.00	Administrative Costs	0	155,952	155,952	0	155,952	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	165,136	165,136	19,285	184,421	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,473,327	254,969	2,728,296	19,285	2,747,581	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1344 | Component CCN: 14-3499 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/21/2023 10:41 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	913,681		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	1,463,080		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	96,566		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	2,473,327		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	89,833		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	89,833		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,563,160		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	0		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	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	28,469		29.00
30.00	Administrative Costs	0	155,952		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	184,421		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,747,581		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1344 | Component CCN: 14-3499 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-2 | Date/Time Prepared: 11/21/2023 10:41 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.74	6,726	4,200	11,508		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	4.64	18,704	2,100	9,744		3.00
4.00	Subtotal (sum of lines 1 through 3)	7.38	25,430		21,252	25,430	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	1.35	1,478			1,478	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	8.73	26,908			26,908	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,563,160	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,563,160	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					184,421	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,210,911	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,395,332	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,395,332	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,395,332	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,958,492	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1344 Component CCN: 14-3499	Period: From 07/01/2022 To 06/30/2023	Worksheet M-3 Date/Time Prepared: 11/21/2023 10:41 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			4,958,492	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			24,733	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			4,933,759	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			26,908	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)			26,908	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			183.36	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)	155.04	160.93		8.00
9.00	Rate for Program covered visits (see instructions)	155.04	160.93		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	2,502	2,558		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	387,910	411,659		11.00
12.00	Program covered visits for mental health services (from contractor records)	33	68		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	5,116	10,943		13.00
14.00	Limit adjustment for mental health services (see instructions)	5,116	10,943		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	815,628		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,068,408		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		142,589		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		108,853		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.)		517,093		16.04
16.05	Total program cost (see instructions)	0	625,946		16.05
17.00	Primary payer amounts		101		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		60,409		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		173,082		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		625,845		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		16,228		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		642,073		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		642,073		26.00
26.01	Sequestration adjustment (see instructions)		12,841		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		614,186		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)		15,046		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: 14-1344 | Component CCN: 14-3499 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-4 | Date/Time Prepared: 11/21/2023 10:41 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,473,327	2,473,327	2,473,327	2,473,327	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.002910	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	7,197	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	5,588	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	12,785	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,563,160	2,563,160	2,563,160	2,563,160	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,395,332	2,395,332	2,395,332	2,395,332	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.004988	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	11,948	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	24,733	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	317	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	78.02	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	208	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	16,228	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)		24,733	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)		16,228	16.00

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

Provider CCN: 14-1344 | Component CCN: 14-3499 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-5 | Date/Time Prepared: 11/21/2023 10:41 am

RHC I | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		614,186	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		614,186	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		15,046	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		629,232	7.00

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