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: 14-1343	Period: From 05/01/2022 To 04/30/2023	Worksheet S Parts I-III Date/Time Prepared: 9/13/2023 2:58 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 9/13/2023 Time: 2:58 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CRAWFORD MEMORIAL HOSPITAL (14-1343) for the cost reporting period beginning 05/01/2022 and ending 04/30/2023 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	Mike Harbor		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	Mike Harbor			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	937,031	-26,103	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	174,935	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		110,006		0	10.00
10.01	RURAL HEALTH CLINIC II	0		16,760		0	10.01
10.02	RURAL HEALTH CLINIC III	0		27,269		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		-37,687		0	10.03
200.00	TOTAL	0	1,111,966	90,245	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: 14-1343	Period: From 05/01/2022 To 04/30/2023	Worksheet S-2 Part I Date/Time Prepared: 9/13/2023 2:58 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 NORTH ALLEN STREET	PO Box:			1.00
2.00	City: ROBINSON	State: IL	Zip Code: 62454	County: CRAWFORD	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	CRAWFORD MEMORIAL HOSPITAL	141343	99914	1	05/01/2005	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	CRAWFORD MEMORIAL HOSPITAL	14Z343	99914		05/01/2005	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	CRAWFORD MEMORIAL HHA	147175	99914		08/01/1979	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	CMH RURAL HEALTH CLINIC	143429	99914		11/11/1996	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	PALESTINE RURAL HEALTH CLINIC	143486	99914		11/21/2006	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	OBLONG RURAL HEALTH CLINIC	143488	99914		05/01/2007	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	CMH RURAL HEALTH CLINIC - MED CTR	148611	99914		05/28/2020	N	O	N	15.03
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)	05/01/2022	04/30/2023	20.00
21.00	Type of Control (see instructions)	11		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 9/13/2023 2:58 pm

		1.00	2.00	3.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 9/13/2023 2:58 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1343	Period: From 05/01/2022 To 04/30/2023	Worksheet S-2 Part I Date/Time Prepared: 9/13/2023 2:58 pm

						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
				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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 9/13/2023 2:58 pm

		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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 9/13/2023 2:58 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	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	N	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)	Y		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N		111.00
		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	253,731	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.		Y	Y	123.00
	Certified Transplant Center Information				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00

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		1.00	2.00	
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1343	Period: From 05/01/2022 To 04/30/2023	Worksheet S-2 Part I Date/Time Prepared: 9/13/2023 2:58 pm

		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: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 9/13/2023 2:58 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	07/12/2023	Y	07/12/2023	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

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		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	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.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4300	KEVIN.WELLEN@CLACONNECT.COM	43.00

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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.	SIGNING DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 9/13/2023 2:58 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	54,288.00	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	54,288.00	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	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	54,288.00	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	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
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

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	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	948	81	2,136			1.00
2.00	HMO and other (see instructions)	0	330				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	268	0	270			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	25			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,216	81	2,431			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		70	254			13.00
14.00	Total (see instructions)	1,216	151	2,685	0.00	308.91	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	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	3,084	0	5,902	0.00	7.49	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	4,616	0	18,467	0.00	25.70	26.00
26.01	RURAL HEALTH CLINIC II	528	0	2,746	0.00	4.00	26.01
26.02	RURAL HEALTH CLINIC III	1,328	0	7,144	0.00	9.30	26.02
26.03	RURAL HEALTH CLINIC IV	663	0	9,680	0.00	17.10	26.03
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	372.50	27.00
28.00	Observation Bed Days		0	337			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			44			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	37	82			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: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 9/13/2023 2:58 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	305	17	736	1.00
2.00	HMO and other (see instructions)			0	158		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	305	17	736	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	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
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

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-1343 | Component CCN: 14-7175 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-4 | Date/Time Prepared: 9/13/2023 2:58 pm

Home Health Agency I | PPS

					1.00		
0.00	County				CRAWFORD		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	1,996	0	70	2,066	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	124.00	2.00	63.00	189.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			1.90	0.00	1.90	5.00
6.00	Direct Nursing Service			3.91	0.00	3.91	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.13	0.00	0.13	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.43	0.00	0.43	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.13	0.00	0.13	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.99	0.00	0.99	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
						CBSA Data	
						1.00	
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					1	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).					99914	20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,484	349	27	14	1,874	21.00
22.00	Skilled Nursing Visit Charges	369,093	86,757	6,723	3,462	466,035	22.00
23.00	Physical Therapy Visits	508	156	1	6	671	23.00
24.00	Physical Therapy Visit Charges	129,645	39,845	256	1,536	171,282	24.00
25.00	Occupational Therapy Visits	63	68	0	1	132	25.00
26.00	Occupational Therapy Visit Charges	16,050	17,369	0	256	33,675	26.00
27.00	Speech Pathology Visits	9	13	1	0	23	27.00
28.00	Speech Pathology Visit Charges	2,304	3,328	256	0	5,888	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	214	166	0	4	384	31.00
32.00	Home Health Aide Visit Charges	25,424	19,682	0	476	45,582	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,278	752	29	25	3,084	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	542,516	166,981	7,235	5,730	722,462	35.00
36.00	Total Number of Episodes (standard/non outlier)	215		23	3	241	36.00
37.00	Total Number of Outlier Episodes		31		0	31	37.00
38.00	Total Non-Routine Medical Supply Charges	60,167	8,794	418	1,081	70,460	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1343 | Component CCN: 14-3429 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-8 | Date/Time Prepared: 9/13/2023 2:58 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1101 N ALLEN		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ROBINSON		IL	62454	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					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		CRAWFORD				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: 14-1343
Component CCN: 14-3429

Period:
From 05/01/2022
To 04/30/2023

Worksheet S-8

Date/Time Prepared:
9/13/2023 2:58 pm

RHC I

Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1343 | Component CCN: 14-3486 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-8 | Date/Time Prepared: 9/13/2023 2:58 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			209 EAST GRAND PRAIRIE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	PALESTINE		IL	62451	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					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	16:30	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		CRAWFORD				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	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1343
Component CCN: 14-3486

Period:
From 05/01/2022
To 04/30/2023

Worksheet S-8

Date/Time Prepared:
9/13/2023 2:58 pm

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:30				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1343 | Component CCN: 14-3488 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-8 | Date/Time Prepared: 9/13/2023 2:58 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1366 E 1050TH AVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	OBLONG		IL	62449	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					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		CRAWFORD				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: 14-1343
Component CCN: 14-3488

Period:
From 05/01/2022
To 04/30/2023

Worksheet S-8

Date/Time Prepared:
9/13/2023 2:58 pm

RHC III

Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1343 | Component CCN: 14-8611 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-8 | Date/Time Prepared: 9/13/2023 2:58 pm

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1000 N ALLEN ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ROBINSON		IL	62454	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		CRAWFORD				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: 14-1343
Component CCN: 14-8611

Period:
From 05/01/2022
To 04/30/2023

Worksheet S-8

Date/Time Prepared:
9/13/2023 2:58 pm

RHC IV

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: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-10 | Date/Time Prepared: 9/13/2023 2:58 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.399541	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,155,985	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	3,307,026	5.00
6.00	Medicaid charges	37,024,121	6.00
7.00	Medicaid cost (line 1 times line 6)	14,792,654	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)	5,329,643	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)	5,329,643	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)	456,395	792,715	1,249,110	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	182,349	792,715	975,064	21.00
22.00	Payments received from patients for amounts previously written off as charity care	89,773	155,927	245,700	22.00
23.00	Cost of charity care (line 21 minus line 22)	92,576	636,788	729,364	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)	3,168,132	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	673,474	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,036,114	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,132,018	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,214,469	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,943,833	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,273,476	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A | Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,934,280	2,934,280	775,727	3,710,007	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,653,247	1,653,247	32,864	1,686,111	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	383,690	6,176,215	6,559,905	0	6,559,905	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	94,428	94,428	5.01
5.02	00550	DATA PROCESSING	291,789	2,530,950	2,822,739	0	2,822,739	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	188,396	236,954	425,350	1,415	426,765	5.03
5.04	00570	ADMITTING	957,924	87,794	1,045,718	-94,428	951,290	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	918,417	848,311	1,766,728	0	1,766,728	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	1,664,752	3,435,485	5,100,237	-167,683	4,932,554	5.06
7.00	00700	OPERATION OF PLANT	480,497	2,058,019	2,538,516	0	2,538,516	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	80,022	55,998	136,020	0	136,020	8.00
9.00	00900	HOUSEKEEPING	611,422	237,284	848,706	0	848,706	9.00
10.00	01000	DIETARY	610,939	395,838	1,006,777	-748,822	257,955	10.00
11.00	01100	CAFETERIA	0	0	0	748,822	748,822	11.00
13.00	01300	NURSING ADMINISTRATION	920,185	89,212	1,009,397	0	1,009,397	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	969,573	969,573	-962,365	7,208	14.00
15.00	01500	PHARMACY	666,458	3,225,160	3,891,618	-2,983,652	907,966	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	508,777	266,617	775,394	0	775,394	16.00
17.00	01700	SOCIAL SERVICE	69,328	5,176	74,504	0	74,504	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,653,412	0	1,653,412	0	1,653,412	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,303,199	1,008,934	4,312,133	-295,295	4,016,838	30.00
43.00	04300	NURSERY	0	19,400	19,400	75,489	94,889	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,116,974	606,321	1,723,295	2,276	1,725,571	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	219,353	219,353	52.00
53.00	05300	ANESTHESIOLOGY	0	139,188	139,188	0	139,188	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	888,747	836,459	1,725,206	-424	1,724,782	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	229,237	18,831	248,068	0	248,068	54.01
60.00	06000	LABORATORY	1,059,248	1,781,289	2,840,537	0	2,840,537	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	72,530	72,530	0	72,530	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	491,942	133,570	625,512	-209	625,303	65.00
66.00	06600	PHYSICAL THERAPY	1,436,769	310,480	1,747,249	-26,318	1,720,931	66.00
69.00	06900	ELECTROCARDIOLOGY	27,550	2,179	29,729	0	29,729	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	739,337	739,337	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	232,230	232,230	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,984,076	2,984,076	73.00
76.97	07697	CARDIAC REHABILITATION	59,978	35,885	95,863	0	95,863	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,902,411	609,980	3,512,391	-25,196	3,487,195	88.00
88.01	08801	RURAL HEALTH CLINIC II	364,412	74,998	439,410	0	439,410	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,019,782	156,595	1,176,377	0	1,176,377	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,487,068	406,372	1,893,440	0	1,893,440	88.03
90.00	09000	CLINIC	2,788,919	2,644,381	5,433,300	-12,053	5,421,247	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	74,334	16,874	91,208	0	91,208	90.01
91.00	09100	EMERGENCY	1,116,991	2,487,052	3,604,043	0	3,604,043	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	522,504	133,840	656,344	51,585	707,929	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		666,353	666,353	-666,353	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,896,073	37,367,624	66,263,697	-25,196	66,238,501	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	11,719	3,240	14,959	25,196	40,155	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	80,583	80,583	0	80,583	194.01
194.02	07952	FOUNDATION	71,288	5,561	76,849	0	76,849	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	28,979,080	37,457,008	66,436,088	0	66,436,088	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A | Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-509,357	3,200,650		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,686,111		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,229,038	3,330,867		4.00
5.01	00540	NONPATIENT TELEPHONES	-916	93,512		5.01
5.02	00550	DATA PROCESSING	0	2,822,739		5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	426,765		5.03
5.04	00570	ADMITTING	0	951,290		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	-775	1,765,953		5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	-612,211	4,320,343		5.06
7.00	00700	OPERATION OF PLANT	-1,739	2,536,777		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	136,020		8.00
9.00	00900	HOUSEKEEPING	0	848,706		9.00
10.00	01000	DIETARY	0	257,955		10.00
11.00	01100	CAFETERIA	-219,851	528,971		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,009,397		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	7,208		14.00
15.00	01500	PHARMACY	-15,066	892,900		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,998	772,396		16.00
17.00	01700	SOCIAL SERVICE	0	74,504		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-1,653,412	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,222,120	2,794,718		30.00
43.00	04300	NURSERY	-19,400	75,489		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,725,571		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	219,353		52.00
53.00	05300	ANESTHESIOLOGY	-20,489	118,699		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-100	1,724,682		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	248,068		54.01
60.00	06000	LABORATORY	0	2,840,537		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	72,530		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	-6,000	619,303		65.00
66.00	06600	PHYSICAL THERAPY	-122,473	1,598,458		66.00
69.00	06900	ELECTROCARDIOLOGY	0	29,729		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	739,337		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	232,230		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,984,076		73.00
76.97	07697	CARDIAC REHABILITATION	-22,885	72,978		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-42,116	3,445,079		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	439,410		88.01
88.02	08802	RURAL HEALTH CLINIC III	-17,885	1,158,492		88.02
88.03	08803	RURAL HEALTH CLINIC IV	-149,879	1,743,561		88.03
90.00	09000	CLINIC	-3,818,399	1,602,848		90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	91,208		90.01
91.00	09100	EMERGENCY	-1,557,755	2,046,288		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	707,929		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,244,864	52,993,637		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	40,155		192.00
194.00	07950	NONREIMBURSEABLE	0	0		194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	80,583		194.01
194.02	07952	FOUNDATION	0	76,849		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,244,864	53,191,224		200.00

RECLASSIFICATIONS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-6 | Date/Time Prepared: 9/13/2023 2:58 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA COSTS				
1.00	CAFETERIA	11.00	454,405	294,417	1.00
	TOTALS		454,405	294,417	
	C - PBX COSTS				
1.00	NONPATIENT TELEPHONES	5.01	86,500	7,928	1.00
	TOTALS		86,500	7,928	
	D - LABOR/DEL & NB COSTS				
1.00	NURSERY	43.00	66,482	9,007	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	193,180	26,173	2.00
	TOTALS		259,662	35,180	
	E - RADIOLOGY CONTRAST ISOVIEW DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	424	1.00
	TOTALS		0	424	
	F - R/C PALESTINE OBLONG DRS				
1.00	PHYSICIANS PRIVATE OFFICES	192.00	21,354	3,842	1.00
	TOTALS		21,354	3,842	
	H - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	666,353	1.00
	TOTALS		0	666,353	
	I - PROPERTY TAX PT				
1.00	PHYSICAL THERAPY	66.00	0	25,445	1.00
	TOTALS		0	25,445	
	J - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	232,230	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	232,230	
	K - RECLASS HHA SALARY IN THERAPY				
1.00	HOME HEALTH AGENCY	101.00	51,585	0	1.00
	TOTALS		51,585	0	
	L - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	142,238	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	142,238	
	M - RECLASS COSTS OF DRUGS SOLD				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,983,652	1.00
	TOTALS		0	2,983,652	
	N - RECLASS COSTS OF MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	739,337	1.00
2.00	PURCHASING RECEIVING AND STORES	5.03	0	1,415	2.00
3.00	OPERATING ROOM	50.00	0	2,276	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		0	743,028	
500.00	Grand Total: Increases		873,506	5,134,737	500.00

RECLASSIFICATIONS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-6 | Date/Time Prepared: 9/13/2023 2:58 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA COSTS						
1.00	DIETARY	10.00	454,405	294,417	0		1.00
	TOTALS		454,405	294,417			
	C - PBX COSTS						
1.00	ADMITTING	5.04	86,500	7,928	0		1.00
	TOTALS		86,500	7,928			
	D - LABOR/DEL & NB COSTS						
1.00	ADULTS & PEDIATRICS	30.00	259,662	35,180	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		259,662	35,180			
	E - RADIOLOGY CONTRAST ISOVIEW DRUGS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	424	0		1.00
	TOTALS		0	424			
	F - R/C PALESTINE OBLONG DRS						
1.00	RURAL HEALTH CLINIC	88.00	21,354	3,842	0		1.00
	TOTALS		21,354	3,842			
	H - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	666,353	11		1.00
	TOTALS		0	666,353			
	I - PROPERTY TAX PT						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	25,445	0		1.00
	TOTALS		0	25,445			
	J - IMPLANTABLE DEVICES						
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	231,205	0		1.00
2.00	CLINIC	90.00	0	1,025	0		2.00
	TOTALS		0	232,230			
	K - RECLASS HHA SALARY IN THERAPY						
1.00	PHYSICAL THERAPY	66.00	51,585	0	0		1.00
	TOTALS		51,585	0			
	L - PROPERTY INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	142,238	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	142,238			
	M - RECLASS COSTS OF DRUGS SOLD						
1.00	PHARMACY	15.00	0	2,983,652	0		1.00
	TOTALS		0	2,983,652			
	N - RECLASS COSTS OF MEDICAL SUPPLIES						
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	731,160	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	453	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	209	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	178	0		4.00
5.00	CLINIC	90.00	0	11,028	0		5.00
	TOTALS		0	743,028			
500.00	Grand Total: Decreases		873,506	5,134,737			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 9/13/2023 2:58 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	540,645	0	0	0	0	1.00
2.00	Land Improvements	1,784,875	955,169	0	955,169	0	2.00
3.00	Buildings and Fixtures	47,207,197	10,052,909	0	10,052,909	4,284	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	9,208,618	108,235	0	108,235	240,531	5.00
6.00	Movable Equipment	20,291,775	1,070,580	0	1,070,580	445,829	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	79,033,110	12,186,893	0	12,186,893	690,644	8.00
9.00	Reconciling Items	-7,007,145	5,872,941	0	5,872,941	0	9.00
10.00	Total (line 8 minus line 9)	86,040,255	6,313,952	0	6,313,952	690,644	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	540,645	0	1.00
2.00	Land Improvements	2,740,044	0	2.00
3.00	Buildings and Fixtures	57,255,822	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	9,076,322	0	5.00
6.00	Movable Equipment	20,916,526	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	90,529,359	0	8.00
9.00	Reconciling Items	-1,134,204	0	9.00
10.00	Total (line 8 minus line 9)	91,663,563	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 9/13/2023 2:58 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,934,280	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,569,285	83,962	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,503,565	83,962	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	2,934,280		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,653,247		2.00
3.00	Total (sum of lines 1-2)	0	4,587,527		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 9/13/2023 2:58 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	69,612,833	0	69,612,833	0.768953	109,374	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	20,916,526	0	20,916,526	0.231047	32,864	2.00
3.00	Total (sum of lines 1-2)	90,529,359	0	90,529,359	1.000000	142,238	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	109,374	2,934,280	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	32,864	1,569,285	83,962	2.00
3.00	Total (sum of lines 1-2)	0	0	142,238	4,503,565	83,962	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	723,153	109,374	0	-566,157	3,200,650	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	32,864	0	0	1,686,111	2.00
3.00	Total (sum of lines 1-2)	723,153	142,238	0	-566,157	4,886,761	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-8 | Date/Time Prepared: 9/13/2023 2:58 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-566,157	CAP REL COSTS-BLDG & FIXT	1.00	14	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,623,004			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-219,851	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,998	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-1,653,412	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	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-8 | Date/Time Prepared: 9/13/2023 2:58 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	PHYSICIAN RECRUITING	A	-107,467	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.00
34.00	EMPLOYEE INJURY	A	50,117	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.00
34.01	EMPLOYEE PHYSICALS	A	-185	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.01
35.00	ADVERTISING	A	-170,770	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	35.00
36.00	TV ADMINISTRATION	A	-16,979	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	36.00
37.00	TV UTILITIES & REPAIR	A	-1,739	OPERATION OF PLANT	7.00	0	37.00
38.00	RENTAL INCOME - CONSULTING CLINIC	B	-28,089	CLINIC	90.00	0	38.00
39.00	EMPLOYEE SALES - PHARMACY	B	-15,066	PHARMACY	15.00	0	39.00
40.00	MISC INCOME	B	-775	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	40.00
41.00	MISC INCOME	B	-189,626	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	41.00
42.00	MISC INCOME	B	-920	ADULTS & PEDIATRICS	30.00	0	42.00
42.01	MISC INCOME	B	-10,184	RURAL HEALTH CLINIC	88.00	0	42.01
42.02	MISC INCOME	B	-28,213	PHYSICAL THERAPY	66.00	0	42.02
42.03	MISC INCOME	B	-18,524	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	42.03
42.04	AHA & IHA DUES	A	-16,169	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	42.04
42.05	NONPATIENT CPR	B	-4,603	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	42.05
42.06	DONATIONS PROJECTS	A	-66,660	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	42.06
42.07	AMORT BOND ISSUE COST	A	56,800	CAP REL COSTS-BLDG & FIXT	1.00	11	42.07
42.08	MRI RENT	B	-100	RADIOLOGY-DIAGNOSTIC	54.00	0	42.08
43.00	OP THERAPY CENTER RENT	B	-94,260	PHYSICAL THERAPY	66.00	0	43.00
44.00	PHYSICIAN & CRNA BENEFITS	A	-98,910	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44.00
45.00	OTHER A&G EXPENSE	A	-27,553	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	45.00
46.00	PATIENT PHONE COSTS	A	-85	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	46.00
47.00	PATIENT PHONE COSTS - SALARY	A	-397	NONPATIENT TELEPHONES	5.01	0	47.00
48.00	PATIENT PHONE COSTS - OTHER	A	-519	NONPATIENT TELEPHONES	5.01	0	48.00
49.00	RHC PHYISICIAN BENEFIT OFFSETS	A	-17,684	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49.00
49.01	NON-RHC EXPENSE	A	-31,932	RURAL HEALTH CLINIC	88.00	0	49.01
49.02	NON-RHC EXPENSE	A	-17,885	RURAL HEALTH CLINIC III	88.02	0	49.02
49.03	NON-RHC EXPENSE	A	-149,879	RURAL HEALTH CLINIC IV	88.03	0	49.03
49.04	HOSPITALIST BILLING EXPENSE	A	-27,419	ADULTS & PEDIATRICS	30.00	0	49.04
49.05	SELF INSURANCE CLAIMS PAID TO CRAWFO	A	-3,143,767	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,244,864				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 9/13/2023 2:58 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,193,781	1,193,781	0	0	0	1.00
2.00	43.00	NURSERY	19,400	19,400	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	20,489	20,489	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	6,000	6,000	0	0	0	4.00
5.00	76.97	CARDIAC REHABILITATION	22,885	22,885	0	0	0	5.00
6.00	90.00	CLINIC	3,790,310	3,790,310	0	0	0	6.00
7.00	91.00	EMERGENCY	1,968,851	1,557,755	411,096	0	0	7.00
8.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	12,384	12,384	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			7,034,100	6,623,004	411,096		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	43.00	NURSERY	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,193,781		1.00
2.00	43.00	NURSERY	0	0	0	19,400		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	20,489		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	6,000		4.00
5.00	76.97	CARDIAC REHABILITATION	0	0	0	22,885		5.00
6.00	90.00	CLINIC	0	0	0	3,790,310		6.00
7.00	91.00	EMERGENCY	0	0	0	1,557,755		7.00
8.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	12,384		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	6,623,004		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 9/13/2023 2:58 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					43	1.00
2.00	Line 1 multiplied by 15 hours per week					645	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					306	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					6.28	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2,259.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	95.99	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	48.00	48.00	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					216,841	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					216,841	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					216,841	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					216,841	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					14,688	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					14,688	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,922	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					16,610	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					16,610	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 9/13/2023 2:58 pm

Physical Therapy | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	95.99	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	216,841		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	16,610		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	233,451		63.00
64.00	Total cost of outside supplier services (from your records)	187,358		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	14,688		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,922		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	16,610		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,922		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	1,922		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part I | Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,200,650	3,200,650				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,686,111		1,686,111			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,330,867	99,437	280	3,430,584		4.00
5.01	00540	NONPATIENT TELEPHONES	93,512	0	0	12,104	105,616	5.01
5.02	00550	DATA PROCESSING	2,822,739	26,404	596,699	40,829	1,083	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	426,765	44,674	0	26,361	1,354	5.03
5.04	00570	ADMITTING	951,290	64,177	0	121,934	3,521	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,765,953	35,276	9	128,509	4,875	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	4,320,343	257,679	10,216	232,940	8,395	5.06
7.00	00700	OPERATION OF PLANT	2,536,777	171,715	67,094	67,234	542	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	136,020	28,096	6,842	11,197	271	8.00
9.00	00900	HOUSEKEEPING	848,706	19,914	2,367	85,553	271	9.00
10.00	01000	DIETARY	257,955	65,492	5,065	21,903	1,896	10.00
11.00	01100	CAFETERIA	528,971	15,921	14,702	63,583	271	11.00
13.00	01300	NURSING ADMINISTRATION	1,009,397	28,326	1,459	128,757	812	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	7,208	0	0	0	271	14.00
15.00	01500	PHARMACY	892,900	33,518	73,006	93,254	2,708	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	772,396	41,142	1,611	71,191	4,604	16.00
17.00	01700	SOCIAL SERVICE	74,504	1,265	0	9,701	271	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,794,718	319,441	46,459	341,482	13,536	30.00
43.00	04300	NURSERY	75,489	13,522	502	9,302	542	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,725,571	326,358	312,850	156,293	4,333	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	219,353	24,038	1,458	27,031	1,625	52.00
53.00	05300	ANESTHESIOLOGY	118,699	3,516	13,904	0	812	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,724,682	141,877	323,916	124,358	2,979	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	248,068	7,262	42,191	32,076	542	54.01
60.00	06000	LABORATORY	2,840,537	67,611	24,569	148,215	1,896	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	72,530	4,847	0	0	271	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	619,303	21,606	53,089	68,835	542	65.00
66.00	06600	PHYSICAL THERAPY	1,598,458	175,871	811	193,822	4,604	66.00
69.00	06900	ELECTROCARDIOLOGY	29,729	0	0	3,855	271	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	739,337	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	232,230	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,984,076	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	72,978	33,321	6,464	8,392	812	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,445,079	295,748	4,442	398,652	10,562	88.00
88.01	08801	RURAL HEALTH CLINIC II	439,410	40,928	492	50,990	1,625	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,158,492	85,438	1,069	140,190	6,229	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,743,561	107,685	0	189,553	4,333	88.03
90.00	09000	CLINIC	1,602,848	306,691	39,130	160,860	10,562	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	91,208	17,285	13,044	10,401	3,521	90.01
91.00	09100	EMERGENCY	2,046,288	156,861	19,964	156,295	2,166	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	707,929	36,344	0	80,329	2,437	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,993,637	3,119,286	1,683,704	3,415,981	105,345	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	11,403	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	40,155	0	0	4,628	0	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	80,583	69,139	2,407	0	0	194.01
194.02	07952	FOUNDATION	76,849	822	0	9,975	271	194.02
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)	53,191,224	3,200,650	1,686,111	3,430,584	105,616	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part I Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	3,487,754					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	27,301	526,455				5.03
5.04	00570	ADMITTING	143,332	1,083	1,285,337			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	116,031	1,146	0	2,051,799		5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	252,538	9,202	0	0	5,091,313	5.06
7.00	00700	OPERATION OF PLANT	20,476	5,113	0	0	2,868,951	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,718	0	0	185,144	8.00
9.00	00900	HOUSEKEEPING	13,651	7,862	0	0	978,324	9.00
10.00	01000	DIETARY	27,301	4,838	0	0	384,450	10.00
11.00	01100	CAFETERIA	13,651	14,044	0	0	651,143	11.00
13.00	01300	NURSING ADMINISTRATION	54,603	452	0	0	1,223,806	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	468	0	0	7,947	14.00
15.00	01500	PHARMACY	75,079	69,437	0	0	1,239,902	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	88,730	392	0	0	980,066	16.00
17.00	01700	SOCIAL SERVICE	6,825	0	0	0	92,566	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	361,744	7,175	304,369	92,480	4,281,404	30.00
43.00	04300	NURSERY	13,651	182	43,155	8,901	165,246	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	150,158	25,576	192,223	250,754	3,144,116	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,476	530	75,045	18,476	388,032	52.00
53.00	05300	ANESTHESIOLOGY	61,428	1,431	40,212	34,534	274,536	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	95,555	6,044	91,670	406,406	2,917,487	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	6,825	191	30,254	60,676	428,085	54.01
60.00	06000	LABORATORY	88,730	55,772	171,573	362,238	3,761,141	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,825	4,710	5,998	3,095	98,276	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	40,952	3,779	30,985	16,046	855,137	65.00
66.00	06600	PHYSICAL THERAPY	218,411	1,681	30,659	88,544	2,312,861	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	3,153	15,610	52,618	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	48,010	57,047	34,666	879,060	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,080	28,035	13,034	288,379	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	193,779	156,216	227,389	3,561,460	73.00
76.97	07697	CARDIAC REHABILITATION	0	93	0	6,480	128,540	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	607,456	14,519	0	75,882	4,852,340	88.00
88.01	08801	RURAL HEALTH CLINIC II	68,254	1,406	0	9,751	612,856	88.01
88.02	08802	RURAL HEALTH CLINIC III	129,682	2,214	0	26,699	1,550,013	88.02
88.03	08803	RURAL HEALTH CLINIC IV	163,808	3,327	0	48,984	2,261,251	88.03
90.00	09000	CLINIC	348,093	11,412	6,559	71,369	2,557,524	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	75,079	674	0	6,488	217,700	90.01
91.00	09100	EMERGENCY	81,904	7,083	18,184	161,992	2,650,737	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	102,380	2,458	0	11,305	943,182	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,480,929	523,881	1,285,337	2,051,799	52,885,593	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	11,403	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	44,783	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	2,573	0	0	154,702	194.01
194.02	07952	FOUNDATION	6,825	1	0	0	94,743	194.02
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)	3,487,754	526,455	1,285,337	2,051,799	53,191,224	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part I Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	5,091,313					5.06
7.00	00700	OPERATION OF PLANT	303,676	3,172,627				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,597	35,637	240,378			8.00
9.00	00900	HOUSEKEEPING	103,555	25,258	0	1,107,137		9.00
10.00	01000	DIETARY	40,694	83,070	1,875	31,988	542,077	10.00
11.00	01100	CAFETERIA	68,923	20,194	5,439	7,776	0	11.00
13.00	01300	NURSING ADMINISTRATION	129,539	35,929	0	13,835	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	841	0	0	0	0	14.00
15.00	01500	PHARMACY	131,242	42,514	0	16,371	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	103,739	52,184	0	20,095	0	16.00
17.00	01700	SOCIAL SERVICE	9,798	1,605	0	618	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	453,182	405,178	74,775	156,022	426,494	30.00
43.00	04300	NURSERY	17,491	17,152	2,537	6,605	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	332,802	413,951	54,521	159,400	51,399	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	41,073	30,489	7,097	11,741	0	52.00
53.00	05300	ANESTHESIOLOGY	29,059	4,460	0	1,717	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	308,813	179,956	16,105	69,296	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	45,312	9,211	0	3,547	0	54.01
60.00	06000	LABORATORY	398,113	85,758	1,264	33,023	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	10,402	6,148	0	2,367	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	90,515	27,405	94	10,553	0	65.00
66.00	06600	PHYSICAL THERAPY	244,814	223,075	0	14,790	0	66.00
69.00	06900	ELECTROCARDIOLOGY	5,570	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	93,048	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,525	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	376,977	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	13,606	42,264	0	16,275	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	513,602	375,126	2,269	144,450	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	64,870	51,913	90	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	164,067	108,370	215	41,730	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	239,351	136,587	1,794	52,596	0	88.03
90.00	09000	CLINIC	270,711	389,006	6,894	149,795	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	23,043	21,924	108	8,442	0	90.01
91.00	09100	EMERGENCY	280,578	198,963	65,301	76,615	64,184	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	99,835	46,099	0	17,751	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,058,963	3,069,426	240,378	1,067,398	542,077	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,207	14,463	0	5,569	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	4,740	0	0	0	0	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	16,375	87,696	0	33,769	0	194.01
194.02	07952	FOUNDATION	10,028	1,042	0	401	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,091,313	3,172,627	240,378	1,107,137	542,077	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part I | Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	753,475					11.00
13.00	01300	NURSING ADMINISTRATION	27,906	1,431,015				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	8,788			14.00
15.00	01500	PHARMACY	20,930	0	0	1,450,959		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	38,371	0	0	0	1,194,455	16.00
17.00	01700	SOCIAL SERVICE	3,488	0	0	0	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	108,140	633,388	0	8,712	58,433	30.00
43.00	04300	NURSERY	3,488	13,931	0	203	5,624	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	55,813	302,184	0	18,475	158,438	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,977	40,474	0	590	11,674	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	807	21,820	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,371	0	0	4,742	256,748	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	10,465	0	0	0	38,338	54.01
60.00	06000	LABORATORY	55,813	0	0	99	228,879	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	1,956	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	20,930	0	0	1,072	10,138	65.00
66.00	06600	PHYSICAL THERAPY	66,278	0	0	274	55,946	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	9,863	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	6,687	0	21,904	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,101	0	8,235	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,290,732	143,675	73.00
76.97	07697	CARDIAC REHABILITATION	3,488	0	0	0	4,094	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	90,696	0	0	36,127	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	5,247	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	7,868	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	59,301	0	0	11,807	0	88.03
90.00	09000	CLINIC	80,231	14,831	0	48,454	45,094	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	3,488	0	0	2,283	4,099	90.01
91.00	09100	EMERGENCY	55,813	287,353	0	13,414	102,354	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	138,854	0	53	7,143	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	749,987	1,431,015	8,788	1,450,959	1,194,455	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	3,488	0	0	0	0	194.02
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)	753,475	1,431,015	8,788	1,450,959	1,194,455	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part I | Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	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	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	108,075					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	96,187	0	6,701,915	-504,727	6,197,188	30.00
43.00	04300	NURSERY	0	0	232,277	0	232,277	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	4,691,099	2,069	4,693,168	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	538,147	0	538,147	52.00
53.00	05300	ANESTHESIOLOGY	0	0	332,399	0	332,399	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,791,518	0	3,791,518	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	534,958	0	534,958	54.01
60.00	06000	LABORATORY	0	0	4,564,090	0	4,564,090	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	119,149	0	119,149	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	502,658	502,658	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,015,844	0	1,015,844	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,918,038	0	2,918,038	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	68,051	0	68,051	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,000,699	0	1,000,699	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	329,240	0	329,240	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,372,844	0	5,372,844	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	208,267	0	208,267	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	6,014,610	0	6,014,610	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	734,976	0	734,976	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	1,872,263	0	1,872,263	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	2,762,687	0	2,762,687	88.03
90.00	09000	CLINIC	0	0	3,562,540	0	3,562,540	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	281,087	0	281,087	90.01
91.00	09100	EMERGENCY	11,888	0	3,807,200	0	3,807,200	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	1,252,917	0	1,252,917	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	108,075	0	52,706,815	0	52,706,815	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	32,642	0	32,642	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	49,523	0	49,523	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	0	292,542	0	292,542	194.01
194.02	07952	FOUNDATION	0	0	109,702	0	109,702	194.02
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	108,075	0	53,191,224	0	53,191,224	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part II | Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	99,437	280	99,717	99,717	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	352	5.01
5.02	00550	DATA PROCESSING	0	26,404	596,699	623,103	1,187	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	7,869	44,674	0	52,543	766	5.03
5.04	00570	ADMITTING	0	64,177	0	64,177	3,544	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	35,276	9	35,285	3,735	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	29,101	257,679	10,216	296,996	6,771	5.06
7.00	00700	OPERATION OF PLANT	0	171,715	67,094	238,809	1,954	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	28,096	6,842	34,938	325	8.00
9.00	00900	HOUSEKEEPING	0	19,914	2,367	22,281	2,487	9.00
10.00	01000	DIETARY	0	65,492	5,065	70,557	637	10.00
11.00	01100	CAFETERIA	0	15,921	14,702	30,623	1,848	11.00
13.00	01300	NURSING ADMINISTRATION	0	28,326	1,459	29,785	3,742	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	1,900	0	0	1,900	0	14.00
15.00	01500	PHARMACY	0	33,518	73,006	106,524	2,710	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	41,142	1,611	42,753	2,069	16.00
17.00	01700	SOCIAL SERVICE	0	1,265	0	1,265	282	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	699	319,441	46,459	366,599	9,925	30.00
43.00	04300	NURSERY	0	13,522	502	14,024	270	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	103,896	326,358	312,850	743,104	4,543	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	24,038	1,458	25,496	786	52.00
53.00	05300	ANESTHESIOLOGY	0	3,516	13,904	17,420	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	141,877	323,916	465,793	3,615	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	7,262	42,191	49,453	932	54.01
60.00	06000	LABORATORY	24,832	67,611	24,569	117,012	4,308	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,847	0	4,847	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	21,606	53,089	74,695	2,001	65.00
66.00	06600	PHYSICAL THERAPY	25,445	175,871	811	202,127	5,634	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	112	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	33,321	6,464	39,785	244	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	295,748	4,442	300,190	11,592	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	40,928	492	41,420	1,482	88.01
88.02	08802	RURAL HEALTH CLINIC III	210	85,438	1,069	86,717	4,075	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	107,685	0	107,685	5,509	88.03
90.00	09000	CLINIC	701	306,691	39,130	346,522	4,675	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	17,285	13,044	30,329	302	90.01
91.00	09100	EMERGENCY	0	156,861	19,964	176,825	4,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	36,344	0	36,344	2,335	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	194,653	3,119,286	1,683,704	4,997,643	99,292	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	11,403	0	11,403	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	135	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	69,139	2,407	71,546	0	194.01
194.02	07952	FOUNDATION	0	822	0	822	290	194.02
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)	194,653	3,200,650	1,686,111	5,081,414	99,717	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part II | Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	352					5.01
5.02	00550	DATA PROCESSING	4	624,294				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	5	4,887	58,201			5.03
5.04	00570	ADMITTING	12	25,656	120	93,509		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	16	20,769	127	0	59,932	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	28	45,203	1,017	0	0	5.06
7.00	00700	OPERATION OF PLANT	2	3,665	565	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1	0	300	0	0	8.00
9.00	00900	HOUSEKEEPING	1	2,443	869	0	0	9.00
10.00	01000	DIETARY	6	4,887	535	0	0	10.00
11.00	01100	CAFETERIA	1	2,443	1,553	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3	9,774	50	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	1	0	52	0	0	14.00
15.00	01500	PHARMACY	9	13,439	7,676	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15	15,882	43	0	0	16.00
17.00	01700	SOCIAL SERVICE	1	1,222	0	0	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	45	64,751	793	22,147	2,701	30.00
43.00	04300	NURSERY	2	2,443	20	3,139	260	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14	26,878	2,827	13,984	7,323	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5	3,665	59	5,459	540	52.00
53.00	05300	ANESTHESIOLOGY	3	10,995	158	2,925	1,009	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10	17,104	668	6,669	11,878	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	2	1,222	21	2,201	1,772	54.01
60.00	06000	LABORATORY	6	15,882	6,166	12,482	10,579	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1	1,222	521	436	90	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2	7,330	418	2,254	469	65.00
66.00	06600	PHYSICAL THERAPY	15	39,095	186	2,230	2,586	66.00
69.00	06900	ELECTROCARDIOLOGY	1	0	0	229	456	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	5,308	4,150	1,012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,667	2,040	381	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	21,423	11,364	6,641	73.00
76.97	07697	CARDIAC REHABILITATION	3	0	10	0	189	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	35	108,732	1,605	0	2,216	88.00
88.01	08801	RURAL HEALTH CLINIC II	5	12,217	155	0	285	88.01
88.02	08802	RURAL HEALTH CLINIC III	21	23,212	245	0	780	88.02
88.03	08803	RURAL HEALTH CLINIC IV	14	29,321	368	0	1,431	88.03
90.00	09000	CLINIC	35	62,307	1,262	477	2,084	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	12	13,439	75	0	189	90.01
91.00	09100	EMERGENCY	7	14,661	783	1,323	4,731	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	8	18,326	272	0	330	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	351	623,072	57,917	93,509	59,932	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	0	284	0	0	194.01
194.02	07952	FOUNDATION	1	1,222	0	0	0	194.02
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)	352	624,294	58,201	93,509	59,932	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part II | Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	350,015					5.06
7.00	00700	OPERATION OF PLANT	20,877	265,872				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,347	2,986	39,897			8.00
9.00	00900	HOUSEKEEPING	7,119	2,117	0	37,317		9.00
10.00	01000	DIETARY	2,798	6,961	311	1,078	87,770	10.00
11.00	01100	CAFETERIA	4,738	1,692	903	262	0	11.00
13.00	01300	NURSING ADMINISTRATION	8,906	3,011	0	466	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	58	0	0	0	0	14.00
15.00	01500	PHARMACY	9,023	3,563	0	552	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,132	4,373	0	677	0	16.00
17.00	01700	SOCIAL SERVICE	674	134	0	21	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	31,156	33,955	12,410	5,259	69,056	30.00
43.00	04300	NURSERY	1,202	1,437	421	223	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,880	34,692	9,049	5,369	8,322	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,824	2,555	1,178	396	0	52.00
53.00	05300	ANESTHESIOLOGY	1,998	374	0	58	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,231	15,081	2,673	2,336	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	3,115	772	0	120	0	54.01
60.00	06000	LABORATORY	27,370	7,187	210	1,113	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	715	515	0	80	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,223	2,297	16	356	0	65.00
66.00	06600	PHYSICAL THERAPY	16,831	18,694	0	499	0	66.00
69.00	06900	ELECTROCARDIOLOGY	383	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,397	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,099	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,917	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	935	3,542	0	549	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	35,301	31,436	377	4,869	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,460	4,350	15	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	11,279	9,082	36	1,407	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	16,455	11,446	298	1,773	0	88.03
90.00	09000	CLINIC	18,611	32,599	1,144	5,049	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	1,584	1,837	18	285	0	90.01
91.00	09100	EMERGENCY	19,289	16,673	10,838	2,582	10,392	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,864	3,863	0	598	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	347,791	257,224	39,897	35,977	87,770	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	83	1,212	0	188	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	326	0	0	0	0	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	1,126	7,349	0	1,138	0	194.01
194.02	07952	FOUNDATION	689	87	0	14	0	194.02
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)	350,015	265,872	39,897	37,317	87,770	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part II | Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	44,063					11.00
13.00	01300	NURSING ADMINISTRATION	1,632	57,369				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	2,011			14.00
15.00	01500	PHARMACY	1,224	0	0	144,720		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,244	0	0	0	75,188	16.00
17.00	01700	SOCIAL SERVICE	204	0	0	0	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	6,323	25,392	0	869	3,678	30.00
43.00	04300	NURSERY	204	558	0	20	354	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,264	12,114	0	1,843	9,974	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	408	1,623	0	59	735	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	81	1,374	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,244	0	0	473	16,159	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	612	0	0	0	2,413	54.01
60.00	06000	LABORATORY	3,264	0	0	10	14,408	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	123	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,224	0	0	107	638	65.00
66.00	06600	PHYSICAL THERAPY	3,876	0	0	27	3,522	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	621	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,530	0	1,379	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	481	0	518	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	128,738	9,044	73.00
76.97	07697	CARDIAC REHABILITATION	204	0	0	0	258	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,304	0	0	3,603	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	523	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	785	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	3,468	0	0	1,178	0	88.03
90.00	09000	CLINIC	4,692	595	0	4,833	2,839	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	204	0	0	228	258	90.01
91.00	09100	EMERGENCY	3,264	11,520	0	1,338	6,443	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	5,567	0	5	450	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,859	57,369	2,011	144,720	75,188	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	204	0	0	0	0	194.02
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)	44,063	57,369	2,011	144,720	75,188	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part II | Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	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	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	3,803					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,385		658,444	0	658,444	30.00
43.00	04300	NURSERY	0		24,577	0	24,577	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		906,180	0	906,180	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		45,788	0	45,788	52.00
53.00	05300	ANESTHESIOLOGY	0		36,395	0	36,395	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		565,934	0	565,934	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0		62,635	0	62,635	54.01
60.00	06000	LABORATORY	0		219,997	0	219,997	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0		8,550	0	8,550	62.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0		98,030	0	98,030	65.00
66.00	06600	PHYSICAL THERAPY	0		295,322	0	295,322	66.00
69.00	06900	ELECTROCARDIOLOGY	0		1,802	0	1,802	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		19,776	0	19,776	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		7,186	0	7,186	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		203,127	0	203,127	73.00
76.97	07697	CARDIAC REHABILITATION	0		45,719	0	45,719	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		505,260	0	505,260	88.00
88.01	08801	RURAL HEALTH CLINIC II	0		64,912	0	64,912	88.01
88.02	08802	RURAL HEALTH CLINIC III	0		137,639	0	137,639	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0		178,946	0	178,946	88.03
90.00	09000	CLINIC	0		487,724	0	487,724	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0		48,760	0	48,760	90.01
91.00	09100	EMERGENCY	418		285,630	0	285,630	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		74,962	0	74,962	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,803	0	4,983,295	0	4,983,295	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0		12,886	0	12,886	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		461	0	461	192.00
194.00	07950	NONREIMBURSEABLE	0		0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0		81,443	0	81,443	194.01
194.02	07952	FOUNDATION	0		3,329	0	3,329	194.02
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,803	0	5,081,414	0	5,081,414	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VAL UE NEW)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SAL)	NONPATIENT TELEPHONES (#OF PHONES)	DATA PROCESSING (#OF COMPUTERS)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	194,800					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,653,247				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,052	275	24,517,390			4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	86,500	390		5.01
5.02	00550	DATA PROCESSING	1,607	585,069	291,789	4	511	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	2,719	0	188,396	5	4	5.03
5.04	00570	ADMITTING	3,906	0	871,424	13	21	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,147	9	918,417	18	17	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	15,683	10,017	1,664,752	31	37	5.06
7.00	00700	OPERATION OF PLANT	10,451	65,786	480,497	2	3	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,710	6,709	80,022	1	0	8.00
9.00	00900	HOUSEKEEPING	1,212	2,321	611,422	1	2	9.00
10.00	01000	DIETARY	3,986	4,966	156,534	7	4	10.00
11.00	01100	CAFETERIA	969	14,415	454,405	1	2	11.00
13.00	01300	NURSING ADMINISTRATION	1,724	1,431	920,185	3	8	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	1	0	14.00
15.00	01500	PHARMACY	2,040	71,583	666,458	10	11	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,504	1,580	508,777	17	13	16.00
17.00	01700	SOCIAL SERVICE	77	0	69,328	1	1	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,442	45,553	2,440,462	50	53	30.00
43.00	04300	NURSERY	823	492	66,482	2	2	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,863	306,752	1,116,974	16	22	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,463	1,430	193,180	6	3	52.00
53.00	05300	ANESTHESIOLOGY	214	13,633	0	3	9	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,635	317,603	888,747	11	14	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	442	41,369	229,237	2	1	54.01
60.00	06000	LABORATORY	4,115	24,090	1,059,248	7	13	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	295	0	0	1	1	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,315	52,054	491,942	2	6	65.00
66.00	06600	PHYSICAL THERAPY	10,704	795	1,385,184	17	32	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	27,550	1	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,028	6,338	59,978	3	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	18,000	4,355	2,849,125	39	89	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,491	482	364,412	6	10	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,200	1,048	1,001,897	23	19	88.02
88.03	08803	RURAL HEALTH CLINIC IV	6,554	0	1,354,674	16	24	88.03
90.00	09000	CLINIC	18,666	38,367	1,149,617	39	51	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	1,052	12,790	74,334	13	11	90.01
91.00	09100	EMERGENCY	9,547	19,575	1,116,991	8	12	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,212	0	574,089	9	15	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	189,848	1,650,887	24,413,029	389	510	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	694	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	33,073	0	0	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	4,208	2,360	0	0	0	194.01
194.02	07952	FOUNDATION	50	0	71,288	1	1	194.02
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)	3,200,650	1,686,111	3,430,584	105,616	3,487,754	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.430441	1.019878	0.139925	270.810256	6,825.350294	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			99,717	352	624,294	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.004067	0.902564	1,221.710372	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VAL UE NEW)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SAL)	NONPATIENT TELEPHONES (#OF PHONES)	DATA PROCESSING (#OF COMPUTERS)	
			1.00	2.00	4.00	5.01	5.02	
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: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES (COST REQS)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	8,107,130					5.03
5.04	00570	ADMITTING	16,678	17,517,182				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	17,642	0	135,568,763			5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	141,702	0	0	-5,091,313	48,099,911	5.06
7.00	00700	OPERATION OF PLANT	78,739	0	0	0	2,868,951	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	41,855	0	0	0	185,144	8.00
9.00	00900	HOUSEKEEPING	121,067	0	0	0	978,324	9.00
10.00	01000	DIETARY	74,499	0	0	0	384,450	10.00
11.00	01100	CAFETERIA	216,264	0	0	0	651,143	11.00
13.00	01300	NURSING ADMINISTRATION	6,963	0	0	0	1,223,806	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	7,207	0	0	0	7,947	14.00
15.00	01500	PHARMACY	1,069,297	0	0	0	1,239,902	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,035	0	0	0	980,066	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	92,566	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	110,490	4,148,114	6,110,312	0	4,281,404	30.00
43.00	04300	NURSERY	2,808	588,136	588,136	0	165,246	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	393,856	2,619,700	16,567,792	0	3,144,116	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,159	1,022,743	1,220,732	0	388,032	52.00
53.00	05300	ANESTHESIOLOGY	22,040	548,026	2,281,756	0	274,536	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,078	1,249,313	26,854,390	0	2,917,487	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	2,935	412,317	4,008,979	0	428,085	54.01
60.00	06000	LABORATORY	858,864	2,338,273	23,933,812	0	3,761,141	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	72,530	81,747	204,523	0	98,276	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	58,199	422,280	1,060,163	0	855,137	65.00
66.00	06600	PHYSICAL THERAPY	25,891	417,839	5,850,303	0	2,312,861	66.00
69.00	06900	ELECTROCARDIOLOGY	0	42,972	1,031,403	0	52,618	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	739,337	777,465	2,290,448	0	879,060	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	232,230	382,079	861,163	0	288,379	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,984,076	2,128,975	15,024,033	0	3,561,460	73.00
76.97	07697	CARDIAC REHABILITATION	1,426	0	428,118	0	128,540	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	223,591	0	5,013,683	0	4,852,340	88.00
88.01	08801	RURAL HEALTH CLINIC II	21,652	0	644,300	0	612,856	88.01
88.02	08802	RURAL HEALTH CLINIC III	34,100	0	1,764,039	0	1,550,013	88.02
88.03	08803	RURAL HEALTH CLINIC IV	51,239	0	3,236,474	0	2,261,251	88.03
90.00	09000	CLINIC	175,738	89,388	4,715,494	0	2,557,524	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	10,381	0	428,646	0	217,700	90.01
91.00	09100	EMERGENCY	109,082	247,815	10,703,136	0	2,650,737	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	37,845	0	746,928	0	943,182	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,067,495	17,517,182	135,568,763	-5,091,313	47,794,280	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	11,403	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	44,783	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	39,623	0	0	0	154,702	194.01
194.02	07952	FOUNDATION	12	0	0	0	94,743	194.02
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)	526,455	1,285,337	2,051,799		5,091,313	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.064937	0.073376	0.015135		0.105849	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	58,201	93,509	59,932		350,015	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.007179	0.005338	0.000442		0.007277	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES (COST REQS)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
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: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY POUNDS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			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	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT	152,235					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,710	131,036				8.00
9.00	00900	HOUSEKEEPING	1,212	0	137,961			9.00
10.00	01000	DIETARY	3,986	1,022	3,986	16,790		10.00
11.00	01100	CAFETERIA	969	2,965	969	0	216	11.00
13.00	01300	NURSING ADMINISTRATION	1,724	0	1,724	0	8	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	2,040	0	2,040	0	6	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,504	0	2,504	0	11	16.00
17.00	01700	SOCIAL SERVICE	77	0	77	0	1	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,442	40,762	19,442	13,210	31	30.00
43.00	04300	NURSERY	823	1,383	823	0	1	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,863	29,721	19,863	1,592	16	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,463	3,869	1,463	0	2	52.00
53.00	05300	ANESTHESIOLOGY	214	0	214	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,635	8,779	8,635	0	11	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	442	0	442	0	3	54.01
60.00	06000	LABORATORY	4,115	689	4,115	0	16	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	295	0	295	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,315	51	1,315	0	6	65.00
66.00	06600	PHYSICAL THERAPY	10,704	0	1,843	0	19	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,028	0	2,028	0	1	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	18,000	1,237	18,000	0	26	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,491	49	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,200	117	5,200	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	6,554	978	6,554	0	17	88.03
90.00	09000	CLINIC	18,666	3,758	18,666	0	23	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	1,052	59	1,052	0	1	90.01
91.00	09100	EMERGENCY	9,547	35,597	9,547	1,988	16	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,212	0	2,212	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	147,283	131,036	133,009	16,790	215	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	694	0	694	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	4,208	0	4,208	0	0	194.01
194.02	07952	FOUNDATION	50	0	50	0	1	194.02
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)	3,172,627	240,378	1,107,137	542,077	753,475	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.840326	1.834442	8.025000	32.285706	3,488.310185	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	265,872	39,897	37,317	87,770	44,063	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.746458	0.304474	0.270489	5.227516	203.995370	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY POUNDS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICE & SUPPLY (COSTED REQ)	PHARMACY (COSTED REQ.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	
			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	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	160,555					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	971,567				14.00
15.00	01500	PHARMACY	0	0	3,354,512			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	124,910,267		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	100	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	71,064	0	20,142	6,110,312	89	30.00
43.00	04300	NURSERY	1,563	0	469	588,136	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,904	0	42,712	16,567,792	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,541	0	1,363	1,220,732	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,866	2,281,756	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	10,964	26,854,390	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	4,008,979	0	54.01
60.00	06000	LABORATORY	0	0	230	23,933,812	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	204,523	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	2,478	1,060,163	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	633	5,850,303	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,031,403	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	739,337	0	2,290,448	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	232,230	0	861,163	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,984,076	15,024,033	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	428,118	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	83,524	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	12,130	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	18,191	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	27,298	0	0	88.03
90.00	09000	CLINIC	1,664	0	112,023	4,715,494	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	5,278	428,646	0	90.01
91.00	09100	EMERGENCY	32,240	0	31,013	10,703,136	11	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	15,579	0	122	746,928	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	160,555	971,567	3,354,512	124,910,267	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,431,015	8,788	1,450,959	1,194,455	108,075	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.912927	0.009045	0.432540	0.009563	1,080.750000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	57,369	2,011	144,720	75,188	3,803	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.357317	0.002070	0.043142	0.000602	38.030000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICE & SUPPLY (COSTED REQ)	PHARMACY (COSTED REQ.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
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: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00540	NONPATIENT TELEPHONES		5.01
5.02	00550	DATA PROCESSING		5.02
5.03	00560	PURCHASING RECEIVING AND STORES		5.03
5.04	00570	ADMITTING		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL		5.06
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	54.01
60.00	06000	LABORATORY	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	88.03
90.00	09000	CLINIC	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	90.01
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY	0	101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	192.00
194.00	07950	NONREIMBURSEABLE	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	194.01
194.02	07952	FOUNDATION	0	194.02
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	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/13/2023 2:58 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			19.00		
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-2 | Date/Time Prepared: 9/13/2023 2:58 pm

		Description	Worksheet CODE	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		IV THERAPY & OR	1	30.00	-504,727	7.00
8.00		IV THERAPY	1	64.00	502,658	8.00
9.00		OR	1	50.00	2,069	9.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet C Part I Date/Time Prepared: 9/13/2023 2:58 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,197,188		6,197,188	0	0	30.00
43.00	04300	NURSERY	232,277		232,277	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,693,168		4,693,168	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	538,147		538,147	0	0	52.00
53.00	05300	ANESTHESIOLOGY	332,399		332,399	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,791,518		3,791,518	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	534,958		534,958	0	0	54.01
60.00	06000	LABORATORY	4,564,090		4,564,090	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	119,149		119,149	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	502,658		502,658	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,015,844	0	1,015,844	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,918,038	0	2,918,038	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	68,051		68,051	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,000,699		1,000,699	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	329,240		329,240	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,372,844		5,372,844	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	208,267		208,267	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,014,610		6,014,610	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	734,976		734,976	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,872,263		1,872,263	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,762,687		2,762,687	0	0	88.03
90.00	09000	CLINIC	3,562,540		3,562,540	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	281,087		281,087	0	0	90.01
91.00	09100	EMERGENCY	3,807,200		3,807,200	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	760,798		760,798		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,252,917		1,252,917		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	53,467,613	0	53,467,613	0	0	200.00
201.00		Less Observation Beds	760,798		760,798		0	201.00
202.00		Total (see instructions)	52,706,815	0	52,706,815	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet C Part I Date/Time Prepared: 9/13/2023 2:58 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,825,262		3,825,262			30.00
43.00	04300	NURSERY	563,881		563,881			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,480,028	13,454,860	15,934,888	0.294522	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	978,709	197,156	1,175,865	0.457661	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	528,497	1,666,578	2,195,075	0.151429	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,220,925	25,109,422	26,330,347	0.143998	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	399,978	3,462,104	3,862,082	0.138515	0.000000	54.01
60.00	06000	LABORATORY	2,287,231	20,805,169	23,092,400	0.197645	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	79,815	122,776	202,591	0.588126	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	164,800	1,398,956	1,563,756	0.321443	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	402,744	624,447	1,027,191	0.988953	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	417,839	5,312,689	5,730,528	0.509209	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	42,078	972,339	1,014,417	0.067084	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	762,119	1,470,011	2,232,130	0.448316	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	379,388	456,780	836,168	0.393749	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,084,412	12,473,638	14,558,050	0.369063	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	418,413	418,413	0.497755	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,892,853	4,892,853			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	626,490	626,490			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,721,753	1,721,753			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	3,163,835	3,163,835			88.03
90.00	09000	CLINIC	89,388	4,510,811	4,600,199	0.774432	0.000000	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	418,758	418,758	0.671240	0.000000	90.01
91.00	09100	EMERGENCY	236,473	10,326,405	10,562,878	0.360432	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	94,508	527,330	621,838	1.223467	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	746,928	746,928			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,038,075	114,880,501	131,918,576			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	17,038,075	114,880,501	131,918,576			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet C Part I Date/Time Prepared: 9/13/2023 2:58 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000		54.01
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
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part II Date/Time Prepared: 9/13/2023 2:58 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	906,180	15,934,888	0.056868	696,922	39,633	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	45,788	1,175,865	0.038940	16,558	645	52.00
53.00	05300	ANESTHESIOLOGY	36,395	2,195,075	0.016580	147,643	2,448	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	565,934	26,330,347	0.021494	507,110	10,900	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	62,635	3,862,082	0.016218	212,158	3,441	54.01
60.00	06000	LABORATORY	219,997	23,092,400	0.009527	839,847	8,001	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,550	202,591	0.042203	25,123	1,060	62.00
64.00	06400	INTRAVENOUS THERAPY	0	1,563,756	0.000000	54,174	0	64.00
65.00	06500	RESPIRATORY THERAPY	98,030	1,027,191	0.095435	215,926	20,607	65.00
66.00	06600	PHYSICAL THERAPY	295,322	5,730,528	0.051535	179,679	9,260	66.00
69.00	06900	ELECTROCARDIOLOGY	1,802	1,014,417	0.001776	16,092	29	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,776	2,232,130	0.008860	366,092	3,244	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,186	836,168	0.008594	241,274	2,074	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	203,127	14,558,050	0.013953	834,353	11,642	73.00
76.97	07697	CARDIAC REHABILITATION	45,719	418,413	0.109268	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	505,260	4,892,853	0.103265	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	64,912	626,490	0.103612	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	137,639	1,721,753	0.079941	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	178,946	3,163,835	0.056560	0	0	88.03
90.00	09000	CLINIC	487,724	4,600,199	0.106022	312	33	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	48,760	418,758	0.116440	0	0	90.01
91.00	09100	EMERGENCY	285,630	10,562,878	0.027041	13,497	365	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	80,834	621,838	0.129992	16,407	2,133	92.00
200.00		Total (lines 50 through 199)	4,306,146	126,782,505		4,383,167	115,515	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part IV | Date/Time Prepared: 9/13/2023 2:58 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	0	0	54.01
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part IV Date/Time Prepared: 9/13/2023 2:58 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	15,934,888	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,175,865	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,195,075	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	26,330,347	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	3,862,082	0.000000	54.01
60.00	06000	LABORATORY	0	0	0	23,092,400	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	202,591	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,563,756	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,027,191	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,730,528	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,014,417	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,232,130	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	836,168	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,558,050	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	418,413	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,892,853	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	626,490	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,721,753	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	3,163,835	0.000000	88.03
90.00	09000	CLINIC	0	0	0	4,600,199	0.000000	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	0	418,758	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	10,562,878	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	621,838	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	126,782,505		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part IV | Date/Time Prepared: 9/13/2023 2:58 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	696,922	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	16,558	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	147,643	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	507,110	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000	212,158	0	0	0	54.01
60.00	06000	LABORATORY	0.000000	839,847	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	25,123	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	54,174	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	215,926	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	179,679	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	16,092	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	366,092	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	241,274	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	834,353	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	312	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	13,497	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	16,407	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,383,167	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part V Date/Time Prepared: 9/13/2023 2:58 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.294522	0	3,655,920	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.457661	0	494	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.151429	0	489,238	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143998	0	9,430,934	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.138515	0	1,021,433	0	0	54.01
60.00	06000	LABORATORY	0.197645	0	7,236,370	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.588126	0	88,064	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.321443	0	508,789	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.988953	0	181,530	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.509209	0	1,614,413	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.067084	0	388,860	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.448316	0	366,087	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.393749	0	198,458	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.369063	0	7,819,381	1,011	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.497755	0	202,596	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
90.00	09000	CLINIC	0.774432	0	2,255,398	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0.671240	0	233,970	0	0	90.01
91.00	09100	EMERGENCY	0.360432	0	3,130,865	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.223467	0	268,165	0	0	92.00
200.00		Subtotal (see instructions)		0	39,090,965	1,011	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	39,090,965	1,011	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part V Date/Time Prepared: 9/13/2023 2:58 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,076,749	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	226	0		52.00
53.00	05300	ANESTHESIOLOGY	74,085	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,358,036	0		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	141,484	0		54.01
60.00	06000	LABORATORY	1,430,232	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	51,793	0		62.00
64.00	06400	INTRAVENOUS THERAPY	163,547	0		64.00
65.00	06500	RESPIRATORY THERAPY	179,525	0		65.00
66.00	06600	PHYSICAL THERAPY	822,074	0		66.00
69.00	06900	ELECTROCARDIOLOGY	26,086	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	164,123	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	78,143	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,885,844	373		73.00
76.97	07697	CARDIAC REHABILITATION	100,843	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
90.00	09000	CLINIC	1,746,652	0		90.00
90.01	09001	PAIN MANAGEMENT CLINIC	157,050	0		90.01
91.00	09100	EMERGENCY	1,128,464	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	328,091	0		92.00
200.00		Subtotal (see instructions)	11,913,047	373		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	11,913,047	373		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D-1 | Date/Time Prepared: 9/13/2023 2:58 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,768	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,473	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,136	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	212	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)	58	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	25	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)	948	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)	210	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)	58	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	188.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	208.70	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,197,188	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	4,711	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	614,252	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,582,936	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,582,936	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)	2,257.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,140,167	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)	2,140,167	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D-1 | Date/Time Prepared: 9/13/2023 2:58 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	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)	1,434,135	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)	3,574,302	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)	474,088	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	130,938	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	605,026	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)	337	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,257.56	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	760,798	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D-1 | Date/Time Prepared: 9/13/2023 2:58 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	658,444	6,197,188	0.106249	760,798	80,834	90.00
91.00	Nursing Program cost	0	6,197,188	0.000000	760,798	0	91.00
92.00	Allied health cost	0	6,197,188	0.000000	760,798	0	92.00
93.00	All other Medical Education	0	6,197,188	0.000000	760,798	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D-3 | Date/Time Prepared: 9/13/2023 2:58 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,669,641		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.294522	696,922	205,259	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.457661	16,558	7,578	52.00
53.00	05300	ANESTHESIOLOGY	0.151429	147,643	22,357	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143998	507,110	73,023	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.138515	212,158	29,387	54.01
60.00	06000	LABORATORY	0.197645	839,847	165,992	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.588126	25,123	14,775	62.00
64.00	06400	INTRAVENOUS THERAPY	0.321443	54,174	17,414	64.00
65.00	06500	RESPIRATORY THERAPY	0.988953	215,926	213,541	65.00
66.00	06600	PHYSICAL THERAPY	0.509209	179,679	91,494	66.00
69.00	06900	ELECTROCARDIOLOGY	0.067084	16,092	1,080	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.448316	366,092	164,125	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.393749	241,274	95,001	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.369063	834,353	307,929	73.00
76.97	07697	CARDIAC REHABILITATION	0.497755	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	0.774432	312	242	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0.671240	0	0	90.01
91.00	09100	EMERGENCY	0.360432	13,497	4,865	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.223467	16,407	20,073	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,383,167	1,434,135	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,383,167		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1343 | Component CCN: 14-Z343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D-3 | Date/Time Prepared: 9/13/2023 2:58 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.294522	8,228	2,423	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.457661	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.151429	2,605	394	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143998	23,024	3,315	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.138515	3,195	443	54.01
60.00	06000	LABORATORY	0.197645	55,567	10,983	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.588126	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.321443	1,527	491	64.00
65.00	06500	RESPIRATORY THERAPY	0.988953	6,202	6,133	65.00
66.00	06600	PHYSICAL THERAPY	0.509209	118,910	60,550	66.00
69.00	06900	ELECTROCARDIOLOGY	0.067084	1,490	100	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.448316	7,185	3,221	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.393749	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.369063	81,102	29,932	73.00
76.97	07697	CARDIAC REHABILITATION	0.497755	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	0.774432	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0.671240	0	0	90.01
91.00	09100	EMERGENCY	0.360432	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.223467	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		309,035	117,985	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)		309,035		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1343	Period: From 05/01/2022 To 04/30/2023	Worksheet E Part B Date/Time Prepared: 9/13/2023 2:58 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	11,913,420	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)	11,913,420	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)	12,032,554	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)	113,270	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	6,260,937	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)	5,658,347	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)	5,658,347	30.00
31.00	Primary payer payments	334	31.00
32.00	Subtotal (line 30 minus line 31)	5,658,013	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)	917,731	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	596,525	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	612,311	36.00
37.00	Subtotal (see instructions)	6,254,538	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)	6,254,538	40.00
40.01	Sequestration adjustment (see instructions)	115,084	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	6,165,557	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)	-26,103	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: 14-1343	Period: From 05/01/2022 To 04/30/2023	Worksheet E Part B Date/Time Prepared: 9/13/2023 2:58 pm
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet E-1 Part I Date/Time Prepared: 9/13/2023 2:58 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,356,001		7,714,046	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	12/14/2022	68,627	12/14/2022	1,254,588	3.50
3.51		04/27/2023	23,992	04/27/2023	293,901	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)		-92,619		-1,548,489	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,263,382		6,165,557	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		937,031		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		26,103	6.02
7.00	Total Medicare program liability (see instructions)		3,200,413		6,139,454	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: 14-1343 | Component CCN: 14-Z343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 9/13/2023 2:58 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		537,695		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	04/27/2023	1,037		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)		-1,037		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)		536,658		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		174,935		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		711,593		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: 14-1343	Period: From 05/01/2022 To 04/30/2023	Worksheet E-1 Part II Date/Time Prepared: 9/13/2023 2:58 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1343 | Component CCN: 14-Z343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet E-2 | Date/Time Prepared: 9/13/2023 2:58 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	611,076	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)	119,165	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	268	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)	730,241	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	730,241	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)	730,241	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,586	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	722,655	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)	3,501	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	2,276	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	724,931	0	19.00
19.01	Sequestration adjustment (see instructions)	13,338	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	536,658	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)	174,935	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: 14-1343	Period: From 05/01/2022 To 04/30/2023	Worksheet E-3 Part V Date/Time Prepared: 9/13/2023 2:58 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,574,302	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)	3,574,302	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,610,045	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)	3,610,045	19.00
20.00	Deductibles (exclude professional component)	371,940	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,238,105	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,238,105	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	34,308	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	22,300	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	11,875	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,260,405	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)	3,260,405	30.00
30.01	Sequestration adjustment (see instructions)	59,992	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,263,382	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)	937,031	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

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

Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet G | Date/Time Prepared: 9/13/2023 2:58 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5,346,271	0	0	0	1.00
2.00	Temporary investments	1,844,668	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,482,359	0	0	0	4.00
5.00	Other receivable	971,852	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	850,397	0	0	0	7.00
8.00	Prepaid expenses	532,217	0	0	0	8.00
9.00	Other current assets	-680,733	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)	15,347,031	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	540,645	0	0	0	12.00
13.00	Land improvements	2,740,044	0	0	0	13.00
14.00	Accumulated depreciation	-925,909	0	0	0	14.00
15.00	Buildings	57,255,822	0	0	0	15.00
16.00	Accumulated depreciation	-28,021,935	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	9,076,322	0	0	0	19.00
20.00	Accumulated depreciation	-8,548,849	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	20,916,526	0	0	0	23.00
24.00	Accumulated depreciation	-15,624,145	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	1,134,204	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	38,542,725	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	41,575,418	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	5,604,484	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	47,179,902	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	101,069,658	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,150,268	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,440,749	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,723,210	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	808,025	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,122,252	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	23,458,590	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	5,604,484	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	29,063,074	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	38,185,326	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	62,884,332				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)	62,884,332	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	101,069,658	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet G-1 | Date/Time Prepared: 9/13/2023 2:58 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		57,364,305		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,520,027				2.00
3.00	Total (sum of line 1 and line 2)		62,884,332		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)		62,884,332		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		62,884,332		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	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 9/13/2023 2:58 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,131,503		4,131,503	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	311,037		311,037	5.00
6.00	Swing bed - NF	28,800		28,800	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	4,471,340		4,471,340	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)	4,471,340		4,471,340	17.00
18.00	Ancillary services	12,613,708	90,596,821	103,210,529	18.00
19.00	Outpatient services	436,284	16,045,186	16,481,470	19.00
20.00	RURAL HEALTH CLINIC	0	5,016,966	5,016,966	20.00
20.01	RURAL HEALTH CLINIC II	0	644,300	644,300	20.01
20.02	RURAL HEALTH CLINIC III	0	1,764,039	1,764,039	20.02
20.03	RURAL HEALTH CLINIC IV	0	3,236,474	3,236,474	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		746,928	746,928	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	2,269,648	17,606,513	19,876,161	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	19,790,980	135,657,227	155,448,207	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		66,436,088		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	INTEREST EXPENSE	666,353			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)		666,353		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		65,769,735		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1343	Period: From 05/01/2022 To 04/30/2023	Worksheet G-3 Date/Time Prepared: 9/13/2023 2:58 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	155,448,207	1.00
2.00	Less contractual allowances and discounts on patients' accounts	87,734,781	2.00
3.00	Net patient revenues (line 1 minus line 2)	67,713,426	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	65,769,735	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,943,691	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	4,073	6.00
7.00	Income from investments	590,889	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	219,851	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	2,998	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	86,689	22.00
23.00	Governmental appropriations	1,239,246	23.00
24.00	MISCELLANEOUS INCOME	376,483	24.00
24.01	UNREALIZED GAINS ON INVESTMENTS	213,382	24.01
24.02	340B NET INCOME	1,116,822	24.02
24.50	COVID-19 PHE Funding	400,000	24.50
25.00	Total other income (sum of lines 6-24)	4,250,433	25.00
26.00	Total (line 5 plus line 25)	6,194,124	26.00
27.00	LOSS ON SALE OF CAPITAL ASSETS	7,744	27.00
27.01	INTEREST EXPENSE	666,353	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	674,097	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,520,027	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1343 HHA CCN: 14-7175 | Period: From 05/01/2022 To 04/30/2023 | Worksheet H Date/Time Prepared: 9/13/2023 2:58 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	1,400	1,400	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	215,687	38,609	14,261	16,656	15,450	300,663	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	271,904	0	17,978	0	0	289,882	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	34,913	0	2,308	0	0	37,221	11.00
12.00	Supplies (see instructions)	0	0	0	0	27,056	27,056	12.00
13.00	Drugs	0	0	0	0	122	122	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	522,504	38,609	34,547	16,656	44,028	656,344	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	1,400	0	1,400			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	300,663	0	300,663			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	289,882	0	289,882			6.00
7.00	Physical Therapy	39,374	39,374	0	39,374			7.00
8.00	Occupational Therapy	11,883	11,883	0	11,883			8.00
9.00	Speech Pathology	328	328	0	328			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	37,221	0	37,221			11.00
12.00	Supplies (see instructions)	0	27,056	0	27,056			12.00
13.00	Drugs	0	122	0	122			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	51,585	707,929	0	707,929			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-1343
HHA CCN: 14-7175

Period: From 05/01/2022 To 04/30/2023

Worksheet H-1 Part I
Date/Time Prepared: 9/13/2023 2:58 pm

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	1,400	0	0	1,400		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	300,663	0	0	1,400	0	302,063	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	289,882	0	0	0	0	289,882	6.00
7.00	Physical Therapy	39,374	0	0	0	0	39,374	7.00
8.00	Occupational Therapy	11,883	0	0	0	0	11,883	8.00
9.00	Speech Pathology	328	0	0	0	0	328	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	37,221	0	0	0	0	37,221	11.00
12.00	Supplies (see instructions)	27,056	0	0	0	0	27,056	12.00
13.00	Drugs	122	0	0	0		122	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	707,929	0	0	1,400	0	707,929	24.00

		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	302,063						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	215,743	505,625					6.00
7.00	Physical Therapy	29,304	68,678					7.00
8.00	Occupational Therapy	8,844	20,727					8.00
9.00	Speech Pathology	244	572					9.00
10.00	Medical Social Services	0	0					10.00
11.00	Home Health Aide	27,701	64,922					11.00
12.00	Supplies (see instructions)	20,136	47,192					12.00
13.00	Drugs	91	213					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		707,929					24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-1343 | HHA CCN: 14-7175 | Period: From 05/01/2022 To 04/30/2023 | Worksheet H-1 Part II | Date/Time Prepared: 9/13/2023 2:58 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	2,212		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	2,212	0	-302,063	405,866	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	289,882	6.00
7.00	Physical Therapy	0	0	0	0	0	39,374	7.00
8.00	Occupational Therapy	0	0	0	0	0	11,883	8.00
9.00	Speech Pathology	0	0	0	0	0	328	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	37,221	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	27,056	12.00
13.00	Drugs	0	0	0		0	122	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	2,212	0	-302,063	405,866	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	1,400	0		302,063	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.632911	0.000000		0.744243	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1343 | HHA CCN: 14-7175 | Period: From 05/01/2022 To 04/30/2023 | Worksheet H-2 Part I | Date/Time Prepared: 9/13/2023 2:58 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	
		0	1.00	2.00	4.00	5.01	5.02	
1.00	Administrative and General	0	36,344	0	30,180	2,437	102,380	1.00
2.00	Skilled Nursing Care	505,625	0	0	38,046	0	0	2.00
3.00	Physical Therapy	68,678	0	0	5,509	0	0	3.00
4.00	Occupational Therapy	20,727	0	0	1,663	0	0	4.00
5.00	Speech Pathology	572	0	0	46	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	64,922	0	0	4,885	0	0	7.00
8.00	Supplies (see instructions)	47,192	0	0	0	0	0	8.00
9.00	Drugs	213	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	707,929	36,344	0	80,329	2,437	102,380	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	
		5.03	5.04	5.05	5A.05	5.06	7.00	
1.00	Administrative and General	2,458	0	11,305	185,104	19,593	46,099	1.00
2.00	Skilled Nursing Care	0	0	0	543,671	57,547	0	2.00
3.00	Physical Therapy	0	0	0	74,187	7,853	0	3.00
4.00	Occupational Therapy	0	0	0	22,390	2,370	0	4.00
5.00	Speech Pathology	0	0	0	618	65	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	69,807	7,389	0	7.00
8.00	Supplies (see instructions)	0	0	0	47,192	4,995	0	8.00
9.00	Drugs	0	0	0	213	23	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	2,458	0	11,305	943,182	99,835	46,099	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1343 | HHA CCN: 14-7175 | Period: From 05/01/2022 To 04/30/2023 | Worksheet H-2 Part I | Date/Time Prepared: 9/13/2023 2:58 pm

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	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	17,751	0	0	138,854	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	17,751	0	0	138,854	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		15.00	16.00	17.00	19.00	24.00	25.00	
1.00	Administrative and General	53	7,143	0	0	414,597	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	601,218	0	2.00
3.00	Physical Therapy	0	0	0	0	82,040	0	3.00
4.00	Occupational Therapy	0	0	0	0	24,760	0	4.00
5.00	Speech Pathology	0	0	0	0	683	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	77,196	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	52,187	0	8.00
9.00	Drugs	0	0	0	0	236	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	53	7,143	0	0	1,252,917	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1343 HHA CCN: 14-7175

Period: From 05/01/2022 To 04/30/2023

Worksheet H-2 Part I Date/Time Prepared: 9/13/2023 2:58 pm

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	Cost Center Description	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		26.00	27.00	28.00			
1.00	Administrative and General	414,597					1.00
2.00	Skilled Nursing Care	601,218	297,337	898,555			2.00
3.00	Physical Therapy	82,040	40,573	122,613			3.00
4.00	Occupational Therapy	24,760	12,245	37,005			4.00
5.00	Speech Pathology	683	338	1,021			5.00
6.00	Medical Social Services	0	0	0			6.00
7.00	Home Health Aide	77,196	38,178	115,374			7.00
8.00	Supplies (see instructions)	52,187	25,809	77,996			8.00
9.00	Drugs	236	117	353			9.00
10.00	DME	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0			13.00
14.00	Clinic	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0			15.00
16.00	Day Care Program	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0			17.00
18.00	Homemaker Service	0	0	0			18.00
19.00	All Others (specify)	0	0	0			19.00
19.50	Telemedicine	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	1,252,917	414,597	1,252,917			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.494557				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1343 HHA CCN: 14-7175

Period: From 05/01/2022 To 04/30/2023

Worksheet H-2 Part II Date/Time Prepared: 9/13/2023 2:58 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VAL UE NEW)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SAL)	NONPATIENT TELEPHONES (#OF PHONES)	DATA PROCESSING (#OF COMPUTERS)	PURCHASING RECEIVING AND STORES (COST REQS)	
		1.00	2.00	4.00	5.01	5.02	5.03	
1.00	Administrative and General	2,212	0	215,687	9	15	37,845	1.00
2.00	Skilled Nursing Care	0	0	271,904	0	0	0	2.00
3.00	Physical Therapy	0	0	39,374	0	0	0	3.00
4.00	Occupational Therapy	0	0	11,883	0	0	0	4.00
5.00	Speech Pathology	0	0	328	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	34,913	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	2,212	0	574,089	9	15	37,845	20.00
21.00	Total cost to be allocated	36,344	0	80,329	2,437	102,380	2,458	21.00
22.00	Unit cost multiplier	16.430380	0.000000	0.139924	270.777778	6,825.333333	0.064949	22.00

	Cost Center Description	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY POUNDS)	
		5.04	5.05	5A.06	5.06	7.00	8.00	
1.00	Administrative and General	0	746,928	0	185,104	2,212	0	1.00
2.00	Skilled Nursing Care	0	0	0	543,671	0	0	2.00
3.00	Physical Therapy	0	0	0	74,187	0	0	3.00
4.00	Occupational Therapy	0	0	0	22,390	0	0	4.00
5.00	Speech Pathology	0	0	0	618	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	69,807	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	47,192	0	0	8.00
9.00	Drugs	0	0	0	213	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	746,928		943,182	2,212	0	20.00
21.00	Total cost to be allocated	0	11,305		99,835	46,099	0	21.00
22.00	Unit cost multiplier	0.000000	0.015135		0.105849	20.840416	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1343 HHA CCN: 14-7175

Period: From 05/01/2022 To 04/30/2023

Worksheet H-2 Part II Date/Time Prepared: 9/13/2023 2:58 pm

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	Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICE & SUPPLY (COSTED REQ)	PHARMACY (COSTED REQ.)	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	2,212	0	0	15,579	0	122	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	2,212	0	0	15,579	0	122	20.00
21.00	Total cost to be allocated	17,751	0	0	138,854	0	53	21.00
22.00	Unit cost multiplier	8.024864	0.000000	0.000000	8.912896	0.000000	0.434426	22.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)				
		16.00	17.00	19.00				
1.00	Administrative and General	746,928	0	0				1.00
2.00	Skilled Nursing Care	0	0	0				2.00
3.00	Physical Therapy	0	0	0				3.00
4.00	Occupational Therapy	0	0	0				4.00
5.00	Speech Pathology	0	0	0				5.00
6.00	Medical Social Services	0	0	0				6.00
7.00	Home Health Aide	0	0	0				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
19.50	Telemedicine	0	0	0				19.50
20.00	Total (sum of lines 1-19)	746,928	0	0				20.00
21.00	Total cost to be allocated	7,143	0	0				21.00
22.00	Unit cost multiplier	0.009563	0.000000	0.000000				22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-1343 | HHA CCN: 14-7175 | Period: From 05/01/2022 To 04/30/2023 | Worksheet H-3 Part I | Date/Time Prepared: 9/13/2023 2:58 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	898,555		898,555	3,003	299.22	1.00
2.00	Physical Therapy	3.00	122,613	0	122,613	1,002	122.37	2.00
3.00	Occupational Therapy	4.00	37,005	0	37,005	220	168.20	3.00
4.00	Speech Pathology	5.00	1,021	0	1,021	26	39.27	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	115,374		115,374	1,651	69.88	6.00
7.00	Total (sum of lines 1-6)		1,174,568	0	1,174,568	5,902		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	1,874			8.00
9.00	Physical Therapy		99914	0	671			9.00
10.00	Occupational Therapy		99914	0	132			10.00
11.00	Speech Pathology		99914	0	23			11.00
12.00	Medical Social Services		99914	0	0			12.00
13.00	Home Health Aide		99914	0	384			13.00
14.00	Total (sum of lines 8-13)			0	3,084			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	77,996	0	77,996	70,460	1.106954	15.00
16.00	Cost of Drugs	9.00	353	0	353	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,874		0	560,738		1.00
2.00	Physical Therapy	0	671		0	82,110		2.00
3.00	Occupational Therapy	0	132		0	22,202		3.00
4.00	Speech Pathology	0	23		0	903		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	384		0	26,834		6.00
7.00	Total (sum of lines 1-6)	0	3,084		0	692,787		7.00

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-1343 HHA CCN: 14-7175 | Period: From 05/01/2022 To 04/30/2023 | Worksheet H-3 Part I Date/Time Prepared: 9/13/2023 2:58 pm

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	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	560,738	1.00
2.00	Physical Therapy	82,110	2.00
3.00	Occupational Therapy	22,202	3.00
4.00	Speech Pathology	903	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	26,834	6.00
7.00	Total (sum of lines 1-6)	692,787	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
9.00	Physical Therapy		9.00
10.00	Occupational Therapy		10.00
11.00	Speech Pathology		11.00
12.00	Medical Social Services		12.00
13.00	Home Health Aide		13.00
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1343
HHA CCN: 14-7175

Period:
From 05/01/2022
To 04/30/2023

Worksheet H-3
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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.509209	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.448316	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.369063	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1343 | HHA CCN: 14-7175 | Period: From 05/01/2022 To 04/30/2023 | Worksheet H-4 Part I-II | Date/Time Prepared: 9/13/2023 2:58 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	395,670	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	59,440	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	4,905	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	3,899	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	13,522	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	477,436	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	477,436	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	477,436	26.00
27.00	Allowable bad debts (from your records)		0	27.00
27.01	Adjusted reimbursable bad debts (see instructions)		0	27.01
28.00	Allowable bad debts for dual eligible (see instructions)		0	28.00
29.00	Total costs - current cost reporting period (see instructions)	0	477,436	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	477,436	31.00
31.01	Sequestration adjustment (see instructions)	0	8,820	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
31.75	Sequestration adjustment for non-claims based amounts (see instructions)	0	0	31.75
32.00	Interim payments (see instructions)	0	468,616	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-1343 HHA CCN: 14-7175

Period: From 05/01/2022 To 04/30/2023

Worksheet H-5

Date/Time Prepared: 9/13/2023 2:58 pm

Home Health Agency I

PPS

		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		0		468,616	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			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			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. H-4, Part II, column as appropriate, line 32)		0		468,616	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		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		468,616	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1343 | Component CCN: 14-3429 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-1 | Date/Time Prepared: 9/13/2023 2:58 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,564,942	0	1,564,942	-13,264	1,551,678	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	283,136	0	283,136	-10,218	272,918	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	550,519	0	550,519	0	550,519	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,398,597	0	2,398,597	-23,482	2,375,115	10.00
11.00	Physician Services Under Agreement	0	117,933	117,933	0	117,933	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	117,933	117,933	0	117,933	14.00
15.00	Medical Supplies	0	93,439	93,439	0	93,439	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	56,349	56,349	0	56,349	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	149,788	149,788	0	149,788	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,398,597	267,721	2,666,318	-23,482	2,642,836	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	2,128	2,128	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	2,128	2,128	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	4,947	4,947	0	4,947	29.00
30.00	Administrative Costs	503,814	337,312	841,126	-3,842	837,284	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	503,814	342,259	846,073	-3,842	842,231	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,902,411	609,980	3,512,391	-25,196	3,487,195	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1343 | Component CCN: 14-3429 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-1 | Date/Time Prepared: 9/13/2023 2:58 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-31,932	1,519,746		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	272,918		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	550,519		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-31,932	2,343,183		10.00
11.00	Physician Services Under Agreement	0	117,933		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	117,933		14.00
15.00	Medical Supplies	0	93,439		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	56,349		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	149,788		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-31,932	2,610,904		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	2,128		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	2,128		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	4,947		29.00
30.00	Administrative Costs	-10,184	827,100		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-10,184	832,047		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-42,116	3,445,079		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1343 | Component CCN: 14-3486 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-1 | Date/Time Prepared: 9/13/2023 2:58 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	195,021	0	195,021	-69	194,952	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	61,589	0	61,589	0	61,589	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	256,610	0	256,610	-69	256,541	10.00
11.00	Physician Services Under Agreement	0	21,333	21,333	0	21,333	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	21,333	21,333	0	21,333	14.00
15.00	Medical Supplies	0	12,130	12,130	0	12,130	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	12,130	12,130	0	12,130	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	256,610	33,463	290,073	-69	290,004	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	69	69	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	69	69	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	9,572	9,572	0	9,572	29.00
30.00	Administrative Costs	107,802	31,963	139,765	0	139,765	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	107,802	41,535	149,337	0	149,337	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	364,412	74,998	439,410	0	439,410	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1343 | Component CCN: 14-3486 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-1 | Date/Time Prepared: 9/13/2023 2:58 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	194,952		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	61,589		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	256,541		10.00
11.00	Physician Services Under Agreement	0	21,333		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	21,333		14.00
15.00	Medical Supplies	0	12,130		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	12,130		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	290,004		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	69		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	69		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	9,572		29.00
30.00	Administrative Costs	0	139,765		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	149,337		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	439,410		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1343 | Component CCN: 14-3488 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-1 | Date/Time Prepared: 9/13/2023 2:58 pm

RHC III | 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	422,908	0	422,908	-723	422,185	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	211,829	0	211,829	0	211,829	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	291,228	0	291,228	0	291,228	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	925,965	0	925,965	-723	925,242	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	11,000	11,000	0	11,000	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	11,000	11,000	0	11,000	14.00
15.00	Medical Supplies	0	18,191	18,191	0	18,191	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	15,126	15,126	0	15,126	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	33,317	33,317	0	33,317	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	925,965	44,317	970,282	-723	969,559	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	723	723	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	723	723	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	21,893	21,893	0	21,893	29.00
30.00	Administrative Costs	93,817	90,385	184,202	0	184,202	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	93,817	112,278	206,095	0	206,095	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,019,782	156,595	1,176,377	0	1,176,377	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1343 | Component CCN: 14-3488 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-1 | Date/Time Prepared: 9/13/2023 2:58 pm

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-17,885	404,300		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	211,829		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	291,228		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-17,885	907,357		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	11,000		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	11,000		14.00
15.00	Medical Supplies	0	18,191		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	15,126		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	33,317		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-17,885	951,674		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	723		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	723		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	21,893		29.00
30.00	Administrative Costs	0	184,202		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	206,095		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-17,885	1,158,492		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1343 | Component CCN: 14-8611 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-1 | Date/Time Prepared: 9/13/2023 2:58 pm

RHC IV | 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	678,776	0	678,776	0	678,776	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	320,517	0	320,517	0	320,517	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	388,811	0	388,811	0	388,811	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,388,104	0	1,388,104	0	1,388,104	10.00
11.00	Physician Services Under Agreement	0	237,359	237,359	0	237,359	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	237,359	237,359	0	237,359	14.00
15.00	Medical Supplies	0	31,404	31,404	0	31,404	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	25,332	25,332	0	25,332	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	56,736	56,736	0	56,736	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,388,104	294,095	1,682,199	0	1,682,199	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	7,460	7,460	0	7,460	29.00
30.00	Administrative Costs	98,964	104,817	203,781	0	203,781	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	98,964	112,277	211,241	0	211,241	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,487,068	406,372	1,893,440	0	1,893,440	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1343 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-1

Component CCN: 14-8611 | Date/Time Prepared: 9/13/2023 2:58 pm

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-132,394	546,382		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	320,517		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	388,811		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-132,394	1,255,710		10.00
11.00	Physician Services Under Agreement	-17,485	219,874		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)	-17,485	219,874		14.00
15.00	Medical Supplies	0	31,404		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	25,332		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	56,736		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-149,879	1,532,320		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	7,460		29.00
30.00	Administrative Costs	0	203,781		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	211,241		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-149,879	1,743,561		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1343 | Component CCN: 14-3429 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-2 | Date/Time Prepared: 9/13/2023 2:58 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC I Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	3.20	11,599	4,200	13,440		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.23	6,868	2,100	2,583		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.43	18,467		16,023	18,467	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.43	18,467			18,467	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)					2,610,904	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					2,128	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,613,032	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999186	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					832,047	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,569,531	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,401,578	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					3,401,578	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					3,398,809	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					6,009,713	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1343 | Component CCN: 14-3486 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-2 | Date/Time Prepared: 9/13/2023 2:58 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.80	2,746	2,100	1,680		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.80	2,746		1,680	2,746	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.80	2,746			2,746	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)					290,004	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					69	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					290,073	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999762	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					149,337	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					295,566	15.00
16.00	Total overhead (sum of lines 14 and 15)					444,903	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					444,903	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					444,797	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					734,801	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1343 | Component CCN: 14-3488 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-2 | Date/Time Prepared: 9/13/2023 2:58 pm

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.67	2,179	4,200	2,814		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.22	4,965	2,100	4,662		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.89	7,144		7,476	7,476	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.89	7,144			7,476	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)					951,674	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					723	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					952,397	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999241	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					206,095	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					713,771	15.00
16.00	Total overhead (sum of lines 14 and 15)					919,866	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					919,866	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					919,168	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,870,842	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1343 | Component CCN: 14-8611 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-2 | Date/Time Prepared: 9/13/2023 2:58 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC IV Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.48	325	4,200	2,016		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.90	9,355	2,100	3,990		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.38	9,680		6,006	9,680	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.38	9,680			9,680	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,532,320	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)					1,532,320	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)					211,241	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,019,126	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,230,367	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,230,367	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,230,367	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,762,687	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1343 Component CCN: 14-3429	Period: From 05/01/2022 To 04/30/2023	Worksheet M-3 Date/Time Prepared: 9/13/2023 2:58 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			6,009,713	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			101,168	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			5,908,545	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			18,467	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)			18,467	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			319.95	7.00
		Calculation of Limit (1)			
		Rate Period 1 (05/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 04/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	244.76	254.07		8.00
9.00	Rate for Program covered visits (see instructions)	244.76	254.07		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	3,189	1,427		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	780,540	362,558		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,143,098		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,057,065		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		147,401		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		159,398		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.)		701,463		16.04
16.05	Total program cost (see instructions)	0	860,861		16.05
17.00	Primary payer amounts		93		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		106,871		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		160,559		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		860,768		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		37,308		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		898,076		22.00
23.00	Allowable bad debts (see instructions)		41,419		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		26,922		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		41,419		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)		924,998		26.00
26.01	Sequestration adjustment (see instructions)		17,019		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		797,973		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)		110,006		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1343 Component CCN: 14-3486	Period: From 05/01/2022 To 04/30/2023	Worksheet M-3 Date/Time Prepared: 9/13/2023 2:58 pm
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			734,801	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			7,703	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			727,098	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,746	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)			2,746	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			264.78	7.00
		Calculation of Limit (1)			
		Rate Period 1 (05/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 04/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	255.07	264.76		8.00
9.00	Rate for Program covered visits (see instructions)	255.07	264.76		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	350	178		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	89,275	47,127		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	136,402		16.00
16.01	Total program charges (see instructions)(from contractor's records)		121,303		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		28,343		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		31,871		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.)		69,095		16.04
16.05	Total program cost (see instructions)	0	100,966		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		18,162		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		14,960		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		100,966		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,833		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		104,799		22.00
23.00	Allowable bad debts (see instructions)		7,068		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		4,594		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		7,068		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)		109,393		26.00
26.01	Sequestration adjustment (see instructions)		2,013		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		90,620		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)		16,760		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1343 Component CCN: 14-3488	Period: From 05/01/2022 To 04/30/2023	Worksheet M-3 Date/Time Prepared: 9/13/2023 2:58 pm
	Title XVIII	RHC III	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)			1,870,842	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			13,685	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,857,157	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			7,476	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)			7,476	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			248.42	7.00
		Calculation of Limit (1)			
		Rate Period 1 (05/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 04/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	228.75	237.44		8.00
9.00	Rate for Program covered visits (see instructions)	228.75	237.44		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	903	425		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	206,561	100,912		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	307,473		16.00
16.01	Total program charges (see instructions)(from contractor's records)		307,106		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		27,198		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		27,230		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.)		196,482		16.04
16.05	Total program cost (see instructions)	0	223,712		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		34,641		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		49,053		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		223,712		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		8,168		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		231,880		22.00
23.00	Allowable bad debts (see instructions)		27,986		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		18,191		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		27,986		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)		250,071		26.00
26.01	Sequestration adjustment (see instructions)		4,601		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		218,201		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)		27,269		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1343 Component CCN: 14-8611	Period: From 05/01/2022 To 04/30/2023	Worksheet M-3 Date/Time Prepared: 9/13/2023 2:58 pm
	Title XVIII	RHC IV	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,762,687	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			10,751	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,751,936	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			9,680	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			9,680	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			284.29	7.00
		Calculation of Limit (1)			
		Rate Period 1 (05/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 04/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	311.93	323.78		8.00
9.00	Rate for Program covered visits (see instructions)	284.29	284.29		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	430	233		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	122,245	66,240		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	188,485		16.00
16.01	Total program charges (see instructions)(from contractor's records)		120,704		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		48,275		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		75,384		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.)		83,459		16.04
16.05	Total program cost (see instructions)	0	158,843		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		8,777		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		12,730		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		158,843		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,106		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		162,949		22.00
23.00	Allowable bad debts (see instructions)		4,101		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		2,666		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		4,101		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)		165,615		26.00
26.01	Sequestration adjustment (see instructions)		3,048		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		200,254		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)		-37,687		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: 14-1343 | Component CCN: 14-3429 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-4 | Date/Time Prepared: 9/13/2023 2:58 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,343,183	2,343,183	2,343,183	2,343,183	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000751	0.001787	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,760	4,187	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	30,349	7,656	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	32,109	11,843	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,610,904	2,610,904	2,610,904	2,610,904	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	3,398,809	3,398,809	3,398,809	3,398,809	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.012298	0.004536	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	41,799	15,417	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	73,908	27,260	0	0	10.00
11.00	Total number of injections/infusions (from your records)	185	440	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	399.50	61.95	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	54	254	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)	21,573	15,735	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)		101,168	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)		37,308	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1343 | Component CCN: 14-3486 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-4 | Date/Time Prepared: 9/13/2023 2:58 pm

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	256,541	256,541	256,541	256,541	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000299	0.002733	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	77	701	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,148	1,114	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,225	1,815	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	290,004	290,004	290,004	290,004	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	444,797	444,797	444,797	444,797	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.004224	0.006259	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1,879	2,784	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	3,104	4,599	0	0	10.00
11.00	Total number of injections/infusions (from your records)	7	64	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	443.43	71.86	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	2	41	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)	887	2,946	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)		7,703	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)		3,833	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1343 | Component CCN: 14-3488 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-4 | Date/Time Prepared: 9/13/2023 2:58 pm

Title XVIII | RHC III | 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)	907,357	907,357	907,357	907,357	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000134	0.001974	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	122	1,791	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,969	3,080	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,091	4,871	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	951,674	951,674	951,674	951,674	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	919,168	919,168	919,168	919,168	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.002197	0.005118	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2,019	4,704	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	4,110	9,575	0	0	10.00
11.00	Total number of injections/infusions (from your records)	12	177	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	342.50	54.10	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	9	94	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)	3,083	5,085	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)		13,685	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)		8,168	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1343 | Component CCN: 14-8611 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-4 | Date/Time Prepared: 9/13/2023 2:58 pm

Title XVIII | RHC IV | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,255,710	1,255,710	1,255,710	1,255,710	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000120	0.001067	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	151	1,340	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	2,297	2,175	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,448	3,515	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,532,320	1,532,320	1,532,320	1,532,320	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,230,367	1,230,367	1,230,367	1,230,367	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.001598	0.002294	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1,966	2,822	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	4,414	6,337	0	0	10.00
11.00	Total number of injections/infusions (from your records)	14	125	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	315.29	50.70	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	9	25	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)	2,838	1,268	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)		10,751	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)		4,106	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1343 Component CCN: 14-3429	Period: From 05/01/2022 To 04/30/2023	Worksheet M-5 Date/Time Prepared: 9/13/2023 2:58 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		797,973	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)		797,973	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		110,006	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		907,979	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1343 Component CCN: 14-3486	Period: From 05/01/2022 To 04/30/2023	Worksheet M-5 Date/Time Prepared: 9/13/2023 2:58 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		90,620	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)		90,620	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		16,760	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		107,380	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1343 Component CCN: 14-3488	Period: From 05/01/2022 To 04/30/2023	Worksheet M-5 Date/Time Prepared: 9/13/2023 2:58 pm
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		218,201	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)		218,201	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		27,269	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		245,470	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1343 Component CCN: 14-8611	Period: From 05/01/2022 To 04/30/2023	Worksheet M-5 Date/Time Prepared: 9/13/2023 2:58 pm
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		264,542	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		12/14/2022	64,288	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)		-64,288	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		200,254	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		37,687	6.02
7.00	Total Medicare program liability (see instructions)		162,567	7.00

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