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: 14-1323	Period: From 04/01/2022 To 03/31/2023	Worksheet S Parts I-III Date/Time Prepared: 8/31/2023 10:00 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 8/31/2023 Time: 10:00 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No. 15101
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 MASSAC MEMORIAL HOSPITAL (14-1323) for the cost reporting period beginning 04/01/2022 and ending 03/31/2023 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	Lynn Goines		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	Lynn Goines			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	81,721	252,468	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	5,160	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC (MMC) I	0		111,913		0	10.00
10.01	RURAL HEALTH CLINIC (FCC) II	0		37,841		0	10.01
10.02	RURAL HEALTH CLINIC (ICC) III	0		-18,162		0	10.02
200.00	TOTAL	0	86,881	384,060	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 8/31/2023 10:00 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 28 CHICK STREET	PO Box:			1.00
2.00	City: METROPOLIS	State: IL	Zip Code: 62960-	County: MASSAC	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	MASSAC MEMORIAL HOSPITAL	141323	99914	1	02/01/2003	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MASSAC MEMORIAL HOSPITAL	14Z323	99916		02/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	MASSAC MEMORIAL MEDICAL CLINIC	143478	99916		02/07/2006	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	MASSAC FAMILY CARE CLINIC	148598	99916		05/17/2019	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	MASSAC INTEGRATED CARE CLINIC	148618	99916		10/23/2020	N	O	N	15.02
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)	04/01/2022	03/31/2023	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: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 8/31/2023 10:00 am

		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: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 8/31/2023 10:00 am

		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.				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: 14-1323	Period: From 04/01/2022 To 03/31/2023	Worksheet S-2 Part I Date/Time Prepared: 8/31/2023 10:00 am

						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: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 8/31/2023 10:00 am

		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: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 8/31/2023 10:00 am

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 8/31/2023 10:00 am

				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N		111.00
		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	231,153	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.		N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.				123.00
	Certified Transplant Center Information				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 8/31/2023 10:00 am

		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	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1323	Period: From 04/01/2022 To 03/31/2023	Worksheet S-2 Part I Date/Time Prepared: 8/31/2023 10:00 am

		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: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 8/31/2023 10:00 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	08/31/2021	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	08/13/2023	Y	08/13/2023	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 8/31/2023 10:00 am

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE	LEE	41.00
42.00	Enter the employer/company name of the cost report preparer.	MEDTRACK, INC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	417-268-5953	KYLE.LEE@EDPTS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1323	Period: From 04/01/2022 To 03/31/2023	Worksheet S-2 Part II Date/Time Prepared: 8/31/2023 10:00 am

		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.	PRIN		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: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 8/31/2023 10:00 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	24,896.00	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	24,896.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	24,896.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (MMC)	88.00				0	26.00
26.01	RURAL HEALTH CLINIC (FCC)	88.01				0	26.01
26.02	RURAL HEALTH CLINIC (ICC)	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 8/31/2023 10:00 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,127	103	1,496			1.00
2.00	HMO and other (see instructions)	219	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	236	0	236			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		51	51			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,363	154	1,783			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,363	154	1,783	0.00	180.77	14.00
15.00	CAH visits	6,848	0	40,384			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (MMC)	1,384	0	6,588	0.00	8.95	26.00
26.01	RURAL HEALTH CLINIC (FCC)	1,499	0	6,133	0.00	8.99	26.01
26.02	RURAL HEALTH CLINIC (ICC)	842	0	3,975	0.00	5.16	26.02
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	203.87	27.00
28.00	Observation Bed Days		0	160			28.00
29.00	Ambulance Trips	16					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 8/31/2023 10:00 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	271	27	392	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	271	27	392	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (MMC)	0.00					26.00
26.01	RURAL HEALTH CLINIC (FCC)	0.00					26.01
26.02	RURAL HEALTH CLINIC (ICC)	0.00					26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1323 | Component CCN: 14-3478 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-8 | Date/Time Prepared: 8/31/2023 10:00 am

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	28 CHICK STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	METROPOLIS	IL	62960	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?	Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		MASSAC				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: 14-1323 Component CCN: 14-3478	Period: From 04/01/2022 To 03/31/2023	Worksheet S-8 Date/Time Prepared: 8/31/2023 10:00 am
		RHC I	Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1323 | Component CCN: 14-8598 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-8 | Date/Time Prepared: 8/31/2023 10:00 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			28 CHICK STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	METROPOLIS		IL	62960	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						11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN	
			1.00		2.00	
14.00	RHC/FQHC name, CCN					14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		MASSAC				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						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1323 Component CCN: 14-8598	Period: From 04/01/2022 To 03/31/2023	Worksheet S-8 Date/Time Prepared: 8/31/2023 10:00 am

		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						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1323 | Component CCN: 14-8618 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-8 | Date/Time Prepared: 8/31/2023 10:00 am

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			510 W. 10TH STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	METROPOLIS		IL	62960	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.)			Y	1	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	17:30	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN	
			1.00		2.00	
14.00	RHC/FQHC name, CCN					14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		MASSAC				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	17:30	08:00	17:30	08:00	17:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1323 Component CCN: 14-8618	Period: From 04/01/2022 To 03/31/2023	Worksheet S-8 Date/Time Prepared: 8/31/2023 10:00 am
		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						11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-10 | Date/Time Prepared: 8/31/2023 10:00 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.590896	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	545,042	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	13,909,021	6.00
7.00	Medicaid cost (line 1 times line 6)	8,218,785	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)	7,673,743	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)	7,673,743	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)	10,130	0	10,130	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	5,986	0	5,986	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	5,986	0	5,986	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)	1,265,886	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	599,553	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	922,389	27.01
28.00	Non-Medicare bad debt expense (see instructions)	343,497	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	525,807	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	531,793	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	8,205,536	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A | Date/Time Prepared: 8/31/2023 10:00 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,047,010	1,047,010	220,748	1,267,758	1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE		0	0	0	0	1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG		0	0	0	0	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		955,644	955,644	240,482	1,196,126	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,605,640	4,605,640	0	4,605,640	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,202,568	3,639,961	5,842,529	-46,461	5,796,068	5.00
7.00	00700	OPERATION OF PLANT	237,946	1,192,889	1,430,835	0	1,430,835	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,157	124,134	140,291	0	140,291	8.00
9.00	00900	HOUSEKEEPING	393,699	136,400	530,099	0	530,099	9.00
10.00	01000	DIETARY	346,957	215,403	562,360	-419,115	143,245	10.00
11.00	01100	CAFETERIA	0	0	0	418,384	418,384	11.00
13.00	01300	NURSING ADMINISTRATION	155,646	8,037	163,683	-6,721	156,962	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	212,173	50,147	262,320	-2,400	259,920	16.00
17.00	01700	SOCIAL SERVICE	178,658	18,338	196,996	0	196,996	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,176,047	144,014	1,320,061	250,555	1,570,616	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	227,472	131,529	359,001	-75,421	283,580	50.00
53.00	05300	ANESTHESIOLOGY	0	310,838	310,838	0	310,838	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	670,268	475,789	1,146,057	-80,710	1,065,347	54.00
60.00	06000	LABORATORY	757,093	837,306	1,594,399	-2,400	1,591,999	60.00
65.00	06500	RESPIRATORY THERAPY	401,741	58,053	459,794	-22,304	437,490	65.00
66.00	06600	PHYSICAL THERAPY	636,561	11,662	648,223	-2,400	645,823	66.00
69.00	06900	ELECTROCARDIOLOGY	93,529	165,360	258,889	16,880	275,769	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,330	52,917	114,247	32,412	146,659	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	417,723	549,148	966,871	96,480	1,063,351	73.00
76.00	03550	GERIATRIC PSYCH	242,926	122,852	365,778	-2,400	363,378	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)	657,645	448,955	1,106,600	-273,075	833,525	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	730,917	138,155	869,072	-46,902	822,170	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	653,722	57,987	711,709	-10,785	700,924	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	13,020	62,700	75,720	0	75,720	90.01
91.00	09100	EMERGENCY	921,334	1,343,797	2,265,131	-25,418	2,239,713	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE	60,334	0	60,334	-156	60,178	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	640,323	99,769	740,092	-6,355	733,737	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		252,918	252,918	-252,918	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,105,789	17,257,352	29,363,141	0	29,363,141	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	33,515	2,743	36,258	0	36,258	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	12,139,304	17,260,095	29,399,399	0	29,399,399	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A | Date/Time Prepared: 8/31/2023 10:00 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-138,109	1,129,649		1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	0		1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	0		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-49,722	1,146,404		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,734	4,603,906		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-131,192	5,664,876		5.00
7.00	00700	OPERATION OF PLANT	0	1,430,835		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	140,291		8.00
9.00	00900	HOUSEKEEPING	0	530,099		9.00
10.00	01000	DIETARY	-247	142,998		10.00
11.00	01100	CAFETERIA	0	418,384		11.00
13.00	01300	NURSING ADMINISTRATION	0	156,962		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-39	259,881		16.00
17.00	01700	SOCIAL SERVICE	0	196,996		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-226,721	1,343,895		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	283,580		50.00
53.00	05300	ANESTHESIOLOGY	0	310,838		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,065,347		54.00
60.00	06000	LABORATORY	0	1,591,999		60.00
65.00	06500	RESPIRATORY THERAPY	0	437,490		65.00
66.00	06600	PHYSICAL THERAPY	0	645,823		66.00
69.00	06900	ELECTROCARDIOLOGY	-94,818	180,951		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-8,069	138,590		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-3,476	1,059,875		73.00
76.00	03550	GERIATRIC PSYCH	0	363,378		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (MMC)	-7,689	825,836		88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	822,170		88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0	700,924		88.02
90.00	09000	CLINIC	0	0		90.00
90.01	04951	WOUND CARE	0	75,720		90.01
91.00	09100	EMERGENCY	0	2,239,713		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	60,178		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	733,737		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-661,816	28,701,325		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	FOUNDATION	0	36,258		192.01
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-661,816	28,737,583		200.00

RECLASSIFICATIONS | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-6 | Date/Time Prepared: 8/31/2023 10:00 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	186,843		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	66,075		2.00
	TOTALS		0	252,918		
	B - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	258,129	160,255		1.00
	TOTALS		258,129	160,255		
	C - RENTAL EXPENSE RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	174,407		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
	TOTALS		0	174,407		
	D - MED SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	34,812		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
9.00		0.00	0	0		9.00
	TOTALS		0	34,812		
	E - DRUGS CHARGED RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	96,480		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
	TOTALS		0	96,480		
	I - RECLASS EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	16,880	0		1.00
	TOTALS		16,880	0		
	K - PROPERTY INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	33,905		1.00
	TOTALS		0	33,905		
	L - HOSPITALIST					
1.00	ADULTS & PEDIATRICS	30.00	259,695	0		1.00
	TOTALS		259,695	0		
500.00	Grand Total: Increases		534,704	752,777		500.00

RECLASSIFICATIONS | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-6 | Date/Time Prepared: 8/31/2023 10:00 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	252,918	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	252,918			
	B - CAFETERIA RECLASS						
1.00	DIETARY	10.00	258,129	160,255	0		1.00
	TOTALS		258,129	160,255			
	C - RENTAL EXPENSE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,556	10		1.00
2.00	NURSING ADMINISTRATION	13.00	0	2,400	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,400	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	2,400	0		4.00
5.00	OPERATING ROOM	50.00	0	68,646	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	59,900	0		6.00
7.00	LABORATORY	60.00	0	2,400	0		7.00
8.00	RURAL HEALTH CLINIC (MMC)	88.00	0	2,800	0		8.00
9.00	RURAL HEALTH CLINIC (FCC)	88.01	0	3,486	0		9.00
10.00	GERIATRIC PSYCH	76.00	0	2,400	0		10.00
11.00	EMERGENCY	91.00	0	2,400	0		11.00
12.00	AMBULANCE SERVICES	95.00	0	2,412	0		12.00
13.00	RURAL HEALTH CLINIC (ICC)	88.02	0	1,145	0		13.00
14.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,400	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	2,400	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	4,262	0		16.00
	TOTALS		0	174,407			
	D - MED SUPPLIES RECLASS						
1.00	RURAL HEALTH CLINIC (FCC)	88.01	0	82	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	4,819	0		2.00
3.00	OPERATING ROOM	50.00	0	6,775	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	1,162	0		4.00
5.00	RURAL HEALTH CLINIC (MMC)	88.00	0	155	0		5.00
6.00	EMERGENCY	91.00	0	21,732	0		6.00
7.00	AMBULANCE SERVICES	95.00	0	23	0		7.00
9.00	OTHER OUTPATIENT SERVICE	93.00	0	64	0		9.00
	TOTALS		0	34,812			
	E - DRUGS CHARGED RECLASS						
1.00	DIETARY	10.00	0	731	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	4,321	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,921	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	20,810	0		4.00
6.00	RURAL HEALTH CLINIC (ICC)	88.02	0	9,640	0		6.00
7.00	RURAL HEALTH CLINIC (MMC)	88.00	0	10,425	0		7.00
8.00	RURAL HEALTH CLINIC (FCC)	88.01	0	43,334	0		8.00
9.00	EMERGENCY	91.00	0	1,286	0		9.00
11.00	OTHER OUTPATIENT SERVICE	93.00	0	92	0		11.00
12.00	AMBULANCE SERVICES	95.00	0	3,920	0		12.00
	TOTALS		0	96,480			
	I - RECLASS EKG SALARIES						
1.00	RESPIRATORY THERAPY	65.00	16,880	0	0		1.00
	TOTALS		16,880	0			
	K - PROPERTY INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	33,905	12		1.00
	TOTALS		0	33,905			
	L - HOSPITALIST						
1.00	RURAL HEALTH CLINIC (MMC)	88.00	259,695	0	0		1.00
	TOTALS		259,695	0			
500.00	Grand Total: Decreases		534,704	752,777			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 8/31/2023 10:00 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	237,159	0	0	0	0	1.00
2.00	Land Improvements	1,113,303	31,996	0	31,996	0	2.00
3.00	Buildings and Fixtures	21,853,464	520,594	0	520,594	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	11,387,483	2,234,473	0	2,234,473	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	34,591,409	2,787,063	0	2,787,063	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	34,591,409	2,787,063	0	2,787,063	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	237,159	0	1.00
2.00	Land Improvements	1,145,299	0	2.00
3.00	Buildings and Fixtures	22,374,058	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	13,621,956	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,378,472	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	37,378,472	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 8/31/2023 10:00 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,047,010	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	955,644	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,002,654	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,047,010	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	955,644	2.00
3.00	Total (sum of lines 1-2)	0	2,002,654	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 8/31/2023 10:00 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	23,756,516	0	23,756,516	0.635567	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0.000000	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	13,621,956	0	13,621,956	0.364433	0	2.00
3.00	Total (sum of lines 1-2)	37,378,472	0	37,378,472	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,047,010	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	954,762	174,407	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,001,772	174,407	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	48,734	33,905	0	0	1,129,649	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	17,235	0	0	0	1,146,404	2.00
3.00	Total (sum of lines 1-2)	65,969	33,905	0	0	2,276,053	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-8 | Date/Time Prepared: 8/31/2023 10:00 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-138,109	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - NEW CAP REL COSTS-BLDG AMBULANCE (chapter 2)		0	NEW CAP REL COSTS-BLDG AMBULANCE	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-BLDG EKG (chapter 2)		0	NEW CAP REL COSTS-BLDG EKG	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-48,840	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,060	ADMINISTRATIVE & GENERAL	5.00	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	-321,539			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		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	-39	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
26.01	Depreciation - NEW CAP REL COSTS-BLDG AMBULANCE		0	NEW CAP REL COSTS-BLDG AMBULANCE	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-BLDG EKG		0	NEW CAP REL COSTS-BLDG EKG	1.02	0	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-8 | Date/Time Prepared: 8/31/2023 10:00 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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
33.00	PHYSICIAN RECRUITMENT	A	-1,542	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	DIETARY REBATE	B	-247	DIETARY	10.00	0	34.00
35.00	PHARMACY REBATES	B	-3,476	DRUGS CHARGED TO PATIENTS	73.00	0	35.00
37.00	OTHER REVENUE	B	-75,021	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	PURCHASING REBATES	B	-8,069	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	38.00
42.00	LOBBYING EXPENSE	A	-12,136	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	RHC MISC INCOME	B	-7,689	RURAL HEALTH CLINIC (MMC)	88.00	0	44.00
45.01	PATIENT TV DEPRECIATION	A	-882	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.01
45.02	PATIENT PHONE SALARY	A	-1,088	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	PATIENT PHONE BENEFITS	A	-240	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.03
45.05	MARKETING EXPENSE	A	-40,345	ADMINISTRATIVE & GENERAL	5.00	0	45.05
46.00	MARKETING BENEFITS	A	-1,494	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	46.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-661,816				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: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 8/31/2023 10:00 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	259,696	226,721	32,975	0	0	1.00
2.00	91.00	EMERGENCY	1,168,634	0	1,168,634	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	94,818	94,818	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,523,148	321,539	1,201,609		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	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	226,721		1.00
2.00	91.00	EMERGENCY	0	0	0	0		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	94,818		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	321,539		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part I | Date/Time Prepared: 8/31/2023 10:00 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW BLDG AMBULANCE	NEW BLDG EKG	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,129,649	1,129,649				1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0			1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	0	0	0		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,146,404				1,146,404	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,603,906	4,628	0	0	4,807	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,664,876	231,659	0	0	240,620	5.00
7.00	00700	OPERATION OF PLANT	1,430,835	88,920	0	0	92,358	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	140,291	18,514	0	0	19,229	8.00
9.00	00900	HOUSEKEEPING	530,099	6,817	0	0	7,081	9.00
10.00	01000	DIETARY	142,998	22,287	0	0	23,149	10.00
11.00	01100	CAFETERIA	418,384	9,325	0	0	9,686	11.00
13.00	01300	NURSING ADMINISTRATION	156,962	3,876	0	0	4,026	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	259,881	17,545	0	0	20,496	16.00
17.00	01700	SOCIAL SERVICE	196,996	2,063	0	0	2,143	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,343,895	167,717	0	0	174,202	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	283,580	102,931	0	0	106,911	50.00
53.00	05300	ANESTHESIOLOGY	310,838	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,065,347	55,826	0	0	57,984	54.00
60.00	06000	LABORATORY	1,591,999	13,577	0	0	14,102	60.00
65.00	06500	RESPIRATORY THERAPY	437,490	18,776	0	0	19,502	65.00
66.00	06600	PHYSICAL THERAPY	645,823	39,524	0	0	41,052	66.00
69.00	06900	ELECTROCARDIOLOGY	180,951	34,793	0	0	36,493	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	138,590	15,755	0	0	16,364	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,059,875	6,498	0	0	6,749	73.00
76.00	03550	GERIATRIC PSYCH	363,378	16,450	0	0	17,086	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)	825,836	74,898	0	0	69,411	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	822,170	73,439	0	0	17,761	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	700,924	19,084	0	0	19,822	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	75,720	15,960	0	0	16,577	90.01
91.00	09100	EMERGENCY	2,239,713	66,872	0	0	69,458	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE	60,178	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	733,737	0	0	0	37,346	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,701,325	1,127,734	0	0	1,144,415	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,915	0	0	1,989	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	36,258	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	28,737,583	1,129,649	0	0	1,146,404	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part I | Date/Time Prepared: 8/31/2023 10:00 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,613,341					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	837,052	6,974,207	6,974,207			5.00
7.00	00700	OPERATION OF PLANT	90,427	1,702,540	545,589	2,248,129		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,140	184,174	59,020	51,739	294,933	8.00
9.00	00900	HOUSEKEEPING	149,619	693,616	222,273	19,052	0	9.00
10.00	01000	DIETARY	33,758	222,192	71,203	62,284	1,275	10.00
11.00	01100	CAFETERIA	98,098	535,493	171,602	26,061	0	11.00
13.00	01300	NURSING ADMINISTRATION	59,151	224,015	71,787	10,832	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	80,633	378,555	121,310	49,031	0	16.00
17.00	01700	SOCIAL SERVICE	67,896	269,098	86,234	5,766	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	545,629	2,231,443	715,079	468,707	135,300	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	86,447	579,869	185,823	287,655	12,780	50.00
53.00	05300	ANESTHESIOLOGY	0	310,838	99,610	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	254,724	1,433,881	459,496	156,013	26,210	54.00
60.00	06000	LABORATORY	287,720	1,907,398	611,237	37,944	0	60.00
65.00	06500	RESPIRATORY THERAPY	146,260	622,028	199,333	52,472	0	65.00
66.00	06600	PHYSICAL THERAPY	241,914	968,313	310,302	110,455	21,983	66.00
69.00	06900	ELECTROCARDIOLOGY	41,959	294,196	94,277	97,234	5,752	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,307	194,016	62,174	44,029	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	158,749	1,231,871	394,760	18,160	0	73.00
76.00	03550	GERIATRIC PSYCH	92,320	489,234	156,778	45,973	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)	151,234	1,121,379	359,353	209,314	3,451	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	277,773	1,191,143	381,709	205,236	0	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	248,436	988,266	316,696	53,332	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	4,948	113,205	36,277	44,603	175	90.01
91.00	09100	EMERGENCY	350,137	2,726,180	873,622	186,885	87,782	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
93.00	04040	OTHER OUTPATIENT SERVICE	22,929	83,107	26,632	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	243,344	1,014,427	325,079	0	225	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,600,604	28,684,684	6,957,255	2,242,777	294,933	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,904	1,251	5,352	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	12,737	48,995	15,701	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,613,341	28,737,583	6,974,207	2,248,129	294,933	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part I | Date/Time Prepared: 8/31/2023 10:00 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	934,941					9.00
10.00	01000	DIETARY	0	356,954				10.00
11.00	01100	CAFETERIA	21,685	242,860	997,701			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	16,609	323,243		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,799	0	49,924	0	610,619	16.00
17.00	01700	SOCIAL SERVICE	0	0	25,650	10,431	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	322,568	84,526	176,308	101,151	171,481	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,595	0	25,257	14,490	15,814	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,206	0	92,576	0	45,936	54.00
60.00	06000	LABORATORY	41,085	0	148,004	0	69,604	60.00
65.00	06500	RESPIRATORY THERAPY	31,226	0	62,897	0	4,626	65.00
66.00	06600	PHYSICAL THERAPY	17,540	0	82,945	0	5,379	66.00
69.00	06900	ELECTROCARDIOLOGY	1,595	0	14,938	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	14,840	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,335	0	37,148	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0	6,861	34,495	0	8,821	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)	118,632	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	36,674	0	0	0	107,794	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	29,339	0	50,711	0	6,132	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	1,081	0	3,443	90.01
91.00	09100	EMERGENCY	165,563	0	150,756	86,491	134,689	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	7,371	0	2,905	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	110,680	33,995	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	870,842	334,247	991,510	323,243	610,619	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	64,099	22,707	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	6,191	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	934,941	356,954	997,701	323,243	610,619	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part I | Date/Time Prepared: 8/31/2023 10:00 am

		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
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	397,179					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	397,179	0	4,803,742	0	4,803,742	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	1,123,283	0	1,123,283	50.00
53.00	05300	ANESTHESIOLOGY	0	0	410,448	0	410,448	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,278,318	0	2,278,318	54.00
60.00	06000	LABORATORY	0	0	2,815,272	0	2,815,272	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	972,582	0	972,582	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,516,917	0	1,516,917	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	507,992	0	507,992	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	315,059	0	315,059	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,689,274	0	1,689,274	73.00
76.00	03550	GERIATRIC PSYCH	0	0	742,162	0	742,162	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)	0	0	1,812,129	0	1,812,129	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	0	1,922,556	0	1,922,556	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0	0	1,444,476	0	1,444,476	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	198,784	0	198,784	90.01
91.00	09100	EMERGENCY	0	0	4,411,968	0	4,411,968	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	120,015	0	120,015	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	1,484,406	0	1,484,406	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	397,179	0	28,569,383	0	28,569,383	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	10,507	0	10,507	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	86,806	0	86,806	192.00
192.01	19201	FOUNDATION	0	0	70,887	0	70,887	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	397,179	0	28,737,583	0	28,737,583	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part II | Date/Time Prepared: 8/31/2023 10:00 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	NEW BLDG AMBULANCE	NEW BLDG EKG	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,628	0	0	4,807	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	231,659	0	0	240,620	5.00
7.00	00700	OPERATION OF PLANT	0	88,920	0	0	92,358	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,514	0	0	19,229	8.00
9.00	00900	HOUSEKEEPING	0	6,817	0	0	7,081	9.00
10.00	01000	DIETARY	0	22,287	0	0	23,149	10.00
11.00	01100	CAFETERIA	0	9,325	0	0	9,686	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,876	0	0	4,026	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,545	0	0	20,496	16.00
17.00	01700	SOCIAL SERVICE	0	2,063	0	0	2,143	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	167,717	0	0	174,202	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	102,931	0	0	106,911	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	55,826	0	0	57,984	54.00
60.00	06000	LABORATORY	0	13,577	0	0	14,102	60.00
65.00	06500	RESPIRATORY THERAPY	0	18,776	0	0	19,502	65.00
66.00	06600	PHYSICAL THERAPY	0	39,524	0	0	41,052	66.00
69.00	06900	ELECTROCARDIOLOGY	0	34,793	0	0	36,493	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,755	0	0	16,364	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,498	0	0	6,749	73.00
76.00	03550	GERIATRIC PSYCH	0	16,450	0	0	17,086	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)	0	74,898	0	0	69,411	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	73,439	0	0	17,761	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0	19,084	0	0	19,822	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	15,960	0	0	16,577	90.01
91.00	09100	EMERGENCY	0	66,872	0	0	69,458	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	37,346	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,127,734	0	0	1,144,415	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,915	0	0	1,989	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,129,649	0	0	1,146,404	202.00

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		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,435	9,435				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	472,279	1,710	473,989			5.00
7.00	00700	OPERATION OF PLANT	181,278	185	37,080	218,543		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	37,743	13	4,011	5,030	46,797	8.00
9.00	00900	HOUSEKEEPING	13,898	306	15,106	1,852	0	9.00
10.00	01000	DIETARY	45,436	69	4,839	6,055	202	10.00
11.00	01100	CAFETERIA	19,011	201	11,663	2,533	0	11.00
13.00	01300	NURSING ADMINISTRATION	7,902	121	4,879	1,053	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	38,041	165	8,245	4,766	0	16.00
17.00	01700	SOCIAL SERVICE	4,206	139	5,861	561	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	341,919	1,116	48,599	45,565	21,467	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	209,842	177	12,629	27,963	2,028	50.00
53.00	05300	ANESTHESIOLOGY	0	0	6,770	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	113,810	521	31,228	15,166	4,159	54.00
60.00	06000	LABORATORY	27,679	588	41,541	3,689	0	60.00
65.00	06500	RESPIRATORY THERAPY	38,278	299	13,547	5,101	0	65.00
66.00	06600	PHYSICAL THERAPY	80,576	495	21,089	10,737	3,488	66.00
69.00	06900	ELECTROCARDIOLOGY	71,286	86	6,407	9,452	913	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,119	48	4,225	4,280	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,247	325	26,829	1,765	0	73.00
76.00	03550	GERIATRIC PSYCH	33,536	189	10,655	4,469	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)	144,309	309	24,423	20,348	548	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	91,200	568	25,942	19,951	0	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	38,906	508	21,523	5,184	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	32,537	10	2,465	4,336	28	90.01
91.00	09100	EMERGENCY	136,330	716	59,378	18,167	13,928	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	47	1,810	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	37,346	498	22,093	0	36	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,272,149	9,409	472,837	218,023	46,797	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,904	0	85	520	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	26	1,067	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,276,053	9,435	473,989	218,543	46,797	202.00

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		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	31,162					9.00
10.00	01000	DIETARY	0	56,601				10.00
11.00	01100	CAFETERIA	723	38,509	72,640			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,209	15,164		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	393	0	3,635	0	55,245	16.00
17.00	01700	SOCIAL SERVICE	0	0	1,868	489	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	10,753	13,403	12,836	4,745	15,513	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	53	0	1,839	680	1,431	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,140	0	6,740	0	4,156	54.00
60.00	06000	LABORATORY	1,369	0	10,776	0	6,297	60.00
65.00	06500	RESPIRATORY THERAPY	1,041	0	4,579	0	419	65.00
66.00	06600	PHYSICAL THERAPY	585	0	6,039	0	487	66.00
69.00	06900	ELECTROCARDIOLOGY	53	0	1,088	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,080	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	244	0	2,705	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0	1,088	2,511	0	798	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)	3,954	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	1,222	0	0	0	9,753	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	978	0	3,692	0	555	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	79	0	311	90.01
91.00	09100	EMERGENCY	5,518	0	10,976	4,057	12,186	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	537	0	263	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	5,193	3,076	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,026	53,000	72,189	15,164	55,245	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	2,136	3,601	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	451	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	31,162	56,601	72,640	15,164	55,245	202.00

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		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
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	13,124					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,124		529,040	0	529,040	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		256,642	0	256,642	50.00
53.00	05300	ANESTHESIOLOGY	0		6,770	0	6,770	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		177,920	0	177,920	54.00
60.00	06000	LABORATORY	0		91,939	0	91,939	60.00
65.00	06500	RESPIRATORY THERAPY	0		63,264	0	63,264	65.00
66.00	06600	PHYSICAL THERAPY	0		123,496	0	123,496	66.00
69.00	06900	ELECTROCARDIOLOGY	0		89,285	0	89,285	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		41,752	0	41,752	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		45,115	0	45,115	73.00
76.00	03550	GERIATRIC PSYCH	0		53,246	0	53,246	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)	0		193,891	0	193,891	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0		148,636	0	148,636	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0		71,346	0	71,346	88.02
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	04951	WOUND CARE	0		39,766	0	39,766	90.01
91.00	09100	EMERGENCY	0		261,256	0	261,256	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0		2,657	0	2,657	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		68,242	0	68,242	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,124	0	2,264,263	0	2,264,263	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		4,509	0	4,509	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		5,737	0	5,737	192.00
192.01	19201	FOUNDATION	0		1,544	0	1,544	192.01
193.00	19300	NONPAID WORKERS	0		0	0	0	193.00
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)	13,124	0	2,276,053	0	2,276,053	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B-1 | Date/Time Prepared: 8/31/2023 10:00 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW BLDG AMBULANCE (SQUARE FEET)	NEW BLDG EKG (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	1.02	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	99,092					1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	0				1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	0	0			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				96,818		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	406	0	0	406	12,139,304	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,321	0	0	20,321	2,202,568	5.00
7.00	00700	OPERATION OF PLANT	7,800	0	0	7,800	237,946	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,624	0	0	1,624	16,157	8.00
9.00	00900	HOUSEKEEPING	598	0	0	598	393,699	9.00
10.00	01000	DIETARY	1,955	0	0	1,955	88,828	10.00
11.00	01100	CAFETERIA	818	0	0	818	258,129	11.00
13.00	01300	NURSING ADMINISTRATION	340	0	0	340	155,646	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,539	0	0	1,731	212,173	16.00
17.00	01700	SOCIAL SERVICE	181	0	0	181	178,658	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,712	0	0	14,712	1,435,742	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,029	0	0	9,029	227,472	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,897	0	0	4,897	670,268	54.00
60.00	06000	LABORATORY	1,191	0	0	1,191	757,093	60.00
65.00	06500	RESPIRATORY THERAPY	1,647	0	0	1,647	384,861	65.00
66.00	06600	PHYSICAL THERAPY	3,467	0	0	3,467	636,561	66.00
69.00	06900	ELECTROCARDIOLOGY	3,052	0	0	3,082	110,409	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,382	0	0	1,382	61,330	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	570	0	0	570	417,723	73.00
76.00	03550	GERIATRIC PSYCH	1,443	0	0	1,443	242,926	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)	6,570	0	0	5,862	397,950	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	6,442	0	0	1,500	730,917	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	1,674	0	0	1,674	653,722	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	1,400	0	0	1,400	13,020	90.01
91.00	09100	EMERGENCY	5,866	0	0	5,866	921,334	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	60,334	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	3,154	640,323	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	98,924	0	0	96,650	12,105,789	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	168	0	0	168	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	33,515	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,129,649	0	0	1,146,404	4,613,341	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.400002	0.000000	0.000000	11.840815	0.380033	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					9,435	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000777	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B-1 | Date/Time Prepared: 8/31/2023 10:00 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	
			5A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,974,207	21,763,376				5.00
7.00	00700	OPERATION OF PLANT	0	1,702,540	70,565			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	184,174	1,624	11,793		8.00
9.00	00900	HOUSEKEEPING	0	693,616	598	0	175,905	9.00
10.00	01000	DIETARY	0	222,192	1,955	51	0	10.00
11.00	01100	CAFETERIA	0	535,493	818	0	4,080	11.00
13.00	01300	NURSING ADMINISTRATION	0	224,015	340	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	378,555	1,539	0	2,220	16.00
17.00	01700	SOCIAL SERVICE	0	269,098	181	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	0	2,231,443	14,712	5,410	60,690	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	579,869	9,029	511	300	50.00
53.00	05300	ANESTHESIOLOGY	0	310,838	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,433,881	4,897	1,048	12,080	54.00
60.00	06000	LABORATORY	0	1,907,398	1,191	0	7,730	60.00
65.00	06500	RESPIRATORY THERAPY	0	622,028	1,647	0	5,875	65.00
66.00	06600	PHYSICAL THERAPY	0	968,313	3,467	879	3,300	66.00
69.00	06900	ELECTROCARDIOLOGY	0	294,196	3,052	230	300	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	194,016	1,382	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,231,871	570	0	1,380	73.00
76.00	03550	GERIATRIC PSYCH	0	489,234	1,443	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)	0	1,121,379	6,570	138	22,320	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	1,191,143	6,442	0	6,900	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0	988,266	1,674	0	5,520	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	113,205	1,400	7	0	90.01
91.00	09100	EMERGENCY	0	2,726,180	5,866	3,510	31,150	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	83,107	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,014,427	0	9	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,974,207	21,710,477	70,397	11,793	163,845	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,904	168	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	12,060	192.00
192.01	19201	FOUNDATION	0	48,995	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		6,974,207	2,248,129	294,933	934,941	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.320456	31.858981	25.009158	5.315034	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		473,989	218,543	46,797	31,162	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.021779	3.097045	3.968201	0.177152	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B-1 | Date/Time Prepared: 8/31/2023 10:00 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	NURSING ADMINISTRATION (NURSING FTES)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (ASSIGNEDTIMES)	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	54,312					10.00
11.00	01100	CAFETERIA	36,952	10,152				11.00
13.00	01300	NURSING ADMINISTRATION	0	169	5,733			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	508	0	141,900		16.00
17.00	01700	SOCIAL SERVICE	0	261	185	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	12,861	1,794	1,794	39,850	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	257	257	3,675	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	942	0	10,675	0	54.00
60.00	06000	LABORATORY	0	1,506	0	16,175	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	640	0	1,075	0	65.00
66.00	06600	PHYSICAL THERAPY	0	844	0	1,250	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	152	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	151	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	378	0	0	0	73.00
76.00	03550	GERIATRIC PSYCH	1,044	351	0	2,050	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	0	0	25,050	0	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0	516	0	1,425	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	11	0	800	0	90.01
91.00	09100	EMERGENCY	0	1,534	1,534	31,300	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	75	0	675	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	1,963	7,900	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,857	10,089	5,733	141,900	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	3,455	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	63	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	356,954	997,701	323,243	610,619	397,179	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.572286	98.276300	56.382871	4.303164	3,971.790000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	56,601	72,640	15,164	55,245	13,124	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.042145	7.155240	2.645038	0.389323	131.240000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B-1 | Date/Time Prepared: 8/31/2023 10:00 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE		1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
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
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03550	GERIATRIC PSYCH	0	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC (MMC)	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0	88.02
90.00	09000	CLINIC	0	90.00
90.01	04951	WOUND CARE	0	90.01
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0	95.00
		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
192.01	19201	FOUNDATION	0	192.01
193.00	19300	NONPAID WORKERS	0	193.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	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
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B-2 | Date/Time Prepared: 8/31/2023 10:00 am

		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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet C Part I Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,803,742		4,803,742	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,123,283		1,123,283	0	0	50.00
53.00	05300	ANESTHESIOLOGY	410,448		410,448	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,278,318		2,278,318	0	0	54.00
60.00	06000	LABORATORY	2,815,272		2,815,272	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	972,582	0	972,582	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,516,917	0	1,516,917	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	507,992		507,992	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	315,059		315,059	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,689,274		1,689,274	0	0	73.00
76.00	03550	GERIATRIC PSYCH	742,162		742,162	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)	1,812,129		1,812,129	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	1,922,556		1,922,556	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	1,444,476		1,444,476	0	0	88.02
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	04951	WOUND CARE	198,784		198,784	0	0	90.01
91.00	09100	EMERGENCY	4,411,968		4,411,968	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	405,664		405,664		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	120,015		120,015	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,484,406		1,484,406	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	28,975,047	0	28,975,047	0	0	200.00
201.00		Less Observation Beds	405,664		405,664		0	201.00
202.00		Total (see instructions)	28,569,383	0	28,569,383	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet C Part I Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,736,821		1,736,821			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,309,389	1,309,389	0.857868	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	291,088	291,088	1.410048	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	991,303	15,399,753	16,391,056	0.138998	0.000000	54.00
60.00	06000	LABORATORY	787,457	9,021,414	9,808,871	0.287013	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	142,534	360,482	503,016	1.933501	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	273,222	1,619,904	1,893,126	0.801276	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	409,688	2,358,838	2,768,526	0.183488	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,559	62,029	67,588	4.661464	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	682,176	1,514,539	2,196,715	0.769000	0.000000	73.00
76.00	03550	GERIATRIC PSYCH	0	457,460	457,460	1.622354	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)	0	825,182	825,182			88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	841,265	841,265			88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0	578,035	578,035			88.02
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	04951	WOUND CARE	0	182,425	182,425	1.089675	0.000000	90.01
91.00	09100	EMERGENCY	67,284	5,965,075	6,032,359	0.731384	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,484	167,557	174,041	2.330853	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	102,671	102,671	1.168928	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,189,650	2,189,650	0.677919	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,102,528	43,246,756	48,349,284			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,102,528	43,246,756	48,349,284			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet C Part I Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03550	GERIATRIC PSYCH	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC (MMC)		88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)		88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)		88.02
90.00	09000	CLINIC	0.000000	90.00
90.01	04951	WOUND CARE	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
		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: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part II Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	256,642	1,309,389	0.196001	0	0	50.00
53.00	05300	ANESTHESIOLOGY	6,770	291,088	0.023258	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	177,920	16,391,056	0.010855	582,713	6,325	54.00
60.00	06000	LABORATORY	91,939	9,808,871	0.009373	554,921	5,201	60.00
65.00	06500	RESPIRATORY THERAPY	63,264	503,016	0.125769	48,118	6,052	65.00
66.00	06600	PHYSICAL THERAPY	123,496	1,893,126	0.065234	115,231	7,517	66.00
69.00	06900	ELECTROCARDIOLOGY	89,285	2,768,526	0.032250	268,208	8,650	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	41,752	67,588	0.617743	3,394	2,097	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,115	2,196,715	0.020537	572,153	11,750	73.00
76.00	03550	GERIATRIC PSYCH	53,246	457,460	0.116395	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)	193,891	825,182	0.234968	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	148,636	841,265	0.176682	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	71,346	578,035	0.123429	0	0	88.02
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	04951	WOUND CARE	39,766	182,425	0.217985	0	0	90.01
91.00	09100	EMERGENCY	261,256	6,032,359	0.043309	1,090	47	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	44,676	174,041	0.256698	3,456	887	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	2,657	102,671	0.025879	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,711,657	44,422,813		2,149,284	48,526	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part IV | Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	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
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part IV | Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,309,389	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	291,088	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,391,056	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,808,871	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	503,016	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,893,126	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,768,526	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	67,588	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,196,715	0.000000	73.00
76.00	03550	GERIATRIC PSYCH	0	0	0	457,460	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)	0	0	0	825,182	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	0	0	841,265	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0	0	0	578,035	0.000000	88.02
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	04951	WOUND CARE	0	0	0	182,425	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	6,032,359	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	174,041	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	102,671	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	44,422,813		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part IV | Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	582,713	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	554,921	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	48,118	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	115,231	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	268,208	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3,394	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	572,153	0	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04951	WOUND CARE	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	1,090	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	3,456	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		2,149,284	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part V Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.857868	0	342,461	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.410048	0	75,532	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.138998	0	5,090,555	0	0	54.00
60.00	06000	LABORATORY	0.287013	0	2,644,464	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.933501	0	63,857	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.801276	0	760,684	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.183488	0	934,757	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4.661464	0	24,122	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.769000	0	1,030,984	0	0	73.00
76.00	03550	GERIATRIC PSYCH	1.622354	0	425,392	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)						88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)						88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)						88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04951	WOUND CARE	1.089675	0	133,003	0	0	90.01
91.00	09100	EMERGENCY	0.731384	0	1,559,863	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.330853	0	33,761	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	1.168928	0	92,404	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.677919		0			95.00
200.00		Subtotal (see instructions)		0	13,211,839	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	13,211,839	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part V Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	293,786	0	50.00
53.00	05300	ANESTHESIOLOGY	106,504	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	707,577	0	54.00
60.00	06000	LABORATORY	758,996	0	60.00
65.00	06500	RESPIRATORY THERAPY	123,468	0	65.00
66.00	06600	PHYSICAL THERAPY	609,518	0	66.00
69.00	06900	ELECTROCARDIOLOGY	171,517	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	112,444	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	792,827	0	73.00
76.00	03550	GERIATRIC PSYCH	690,136	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (MMC)			88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)			88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)			88.02
90.00	09000	CLINIC	0	0	90.00
90.01	04951	WOUND CARE	144,930	0	90.01
91.00	09100	EMERGENCY	1,140,859	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	78,692	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	108,014	0	93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	5,839,268	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	5,839,268	0	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1323 | Component CCN: 14-Z323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part IV | Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	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
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 14-1323 | Component CCN: 14-Z323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part IV | Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Swing Beds - SNF | 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	1,309,389	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	291,088	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,391,056	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,808,871	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	503,016	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,893,126	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,768,526	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	67,588	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,196,715	0.000000	73.00
76.00	03550	GERIATRIC PSYCH	0	0	0	457,460	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)	0	0	0	825,182	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0	0	0	841,265	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0	0	0	578,035	0.000000	88.02
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	04951	WOUND CARE	0	0	0	182,425	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	6,032,359	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	174,041	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	102,671	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	44,422,813		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1323 | Component CCN: 14-Z323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part IV | Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	16,063	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	34,635	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	884	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	109,794	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,572	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	382	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	40,916	0	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04951	WOUND CARE	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	3,028	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		210,274	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1323 | Component CCN: 14-Z323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part V | Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Swing Beds - SNF | 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	0.857868	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.410048	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.138998	0	0	0	0	54.00
60.00	06000	LABORATORY	0.287013	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.933501	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.801276	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.183488	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4.661464	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.769000	0	0	0	0	73.00
76.00	03550	GERIATRIC PSYCH	1.622354	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (MMC)						88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)						88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)						88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04951	WOUND CARE	1.089675	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.731384	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.330853	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	1.168928	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.677919		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1323 | Component CCN: 14-Z323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part V | Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Swing Beds - SNF | 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	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03550	GERIATRIC PSYCH	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (MMC)				88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)				88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)				88.02
90.00	09000	CLINIC	0	0		90.00
90.01	04951	WOUND CARE	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-1 | Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,943	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,656	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,496	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	167	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)	69	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	39	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)	12	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,127	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)	167	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)	69	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	132.61	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.61	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,803,742	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)	5,172	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)	1,591	25.00
26.00	Total swing-bed cost (see instructions)	605,117	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,198,625	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)	4,198,625	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)	2,535.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,857,396	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)	2,857,396	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-1 | Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	939,506	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)	3,796,902	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)	423,412	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	174,943	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	598,355	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)	160	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,535.40	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	405,664	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-1 | Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	529,040	4,803,742	0.110131	405,664	44,676	90.00
91.00	Nursing Program cost	0	4,803,742	0.000000	405,664	0	91.00
92.00	Allied health cost	0	4,803,742	0.000000	405,664	0	92.00
93.00	All other Medical Education	0	4,803,742	0.000000	405,664	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-3 | Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		842,071		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.857868	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.410048	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.138998	582,713	80,996	54.00
60.00	06000	LABORATORY	0.287013	554,921	159,270	60.00
65.00	06500	RESPIRATORY THERAPY	1.933501	48,118	93,036	65.00
66.00	06600	PHYSICAL THERAPY	0.801276	115,231	92,332	66.00
69.00	06900	ELECTROCARDIOLOGY	0.183488	268,208	49,213	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4.661464	3,394	15,821	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.769000	572,153	439,986	73.00
76.00	03550	GERIATRIC PSYCH	1.622354	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (MMC)	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0.000000		0	88.02
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	04951	WOUND CARE	1.089675	0	0	90.01
91.00	09100	EMERGENCY	0.731384	1,090	797	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.330853	3,456	8,055	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	1.168928	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,149,284	939,506	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,149,284		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-3

Component CCN: 14-Z323 | Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.857868	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.410048	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.138998	16,063	2,233	54.00
60.00	06000	LABORATORY	0.287013	34,635	9,941	60.00
65.00	06500	RESPIRATORY THERAPY	1.933501	884	1,709	65.00
66.00	06600	PHYSICAL THERAPY	0.801276	109,794	87,975	66.00
69.00	06900	ELECTROCARDIOLOGY	0.183488	4,572	839	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4.661464	382	1,781	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.769000	40,916	31,464	73.00
76.00	03550	GERIATRIC PSYCH	1.622354	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (MMC)	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC (FCC)	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC (ICC)	0.000000		0	88.02
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	04951	WOUND CARE	1.089675	0	0	90.01
91.00	09100	EMERGENCY	0.731384	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.330853	3,028	7,058	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	1.168928	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		210,274	143,000	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)		210,274		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1323	Period: From 04/01/2022 To 03/31/2023	Worksheet E Part B Date/Time Prepared: 8/31/2023 10:00 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,839,268	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,839,268	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	5,897,661	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)	57,851	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,932,698	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,907,112	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	3,907,112	30.00
31.00	Primary payer payments	3,184	31.00
32.00	Subtotal (line 30 minus line 31)	3,903,928	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)	734,448	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	477,391	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	483,950	36.00
37.00	Subtotal (see instructions)	4,381,319	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)	4,381,319	40.00
40.01	Sequestration adjustment (see instructions)	76,673	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	4,052,178	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)	252,468	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: 14-1323	Period: From 04/01/2022 To 03/31/2023	Worksheet E Part B Date/Time Prepared: 8/31/2023 10:00 am
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,671,456		4,777,857	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	10/17/2022	166,633	10/17/2022	555,470	3.50
3.51		03/02/2023	40,669	03/02/2023	170,209	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)		-207,302		-725,679	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)		3,464,154		4,052,178	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		81,721		252,468	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,545,875		4,304,646	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	CGS	15101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1323 | Component CCN: 14-Z323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		809,076		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	10/17/2022	75,476		0	3.50
3.51		03/02/2023	5,863		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)		-81,339		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)		727,737		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		5,160		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		732,897		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	CGS	15101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1323	Period: From 04/01/2022 To 03/31/2023	Worksheet E-1 Part II Date/Time Prepared: 8/31/2023 10:00 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-1323 | Component CCN: 14-Z323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet E-2 | Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	604,339	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)	144,430	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	236	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)	748,769	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	748,769	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)	748,769	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,145	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	745,624	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)	503	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	327	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	503	0	18.00
19.00	Total (see instructions)	745,951	0	19.00
19.01	Sequestration adjustment (see instructions)	13,054	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	727,737	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)	5,160	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: 14-1323	Period: From 04/01/2022 To 03/31/2023	Worksheet E-3 Part V Date/Time Prepared: 8/31/2023 10:00 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,796,902	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)	3,796,902	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,834,871	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)	3,834,871	19.00
20.00	Deductibles (exclude professional component)	307,044	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,527,827	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,527,827	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	124,934	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	81,207	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	70,595	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,609,034	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)	3,609,034	30.00
30.01	Sequestration adjustment (see instructions)	63,159	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	3,464,154	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)	81,721	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: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet G | Date/Time Prepared: 8/31/2023 10:00 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	26,096,159	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,021,269	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,023,109	0	0	0	6.00
7.00	Inventory	273,725	0	0	0	7.00
8.00	Prepaid expenses	712,002	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	29,080,046	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	237,159	0	0	0	12.00
13.00	Land improvements	1,145,299	0	0	0	13.00
14.00	Accumulated depreciation	-1,065,671	0	0	0	14.00
15.00	Buildings	22,330,254	0	0	0	15.00
16.00	Accumulated depreciation	-12,608,635	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	11,497,168	0	0	0	23.00
24.00	Accumulated depreciation	-7,535,927	0	0	0	24.00
25.00	Minor equipment depreciable	2,124,788	0	0	0	25.00
26.00	Accumulated depreciation	-214,830	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	-1,061,020	0	0	0	28.00
29.00	Minor equipment-nondepreciable	43,804	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	14,892,389	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	544,431	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	544,431	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	44,516,866	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	420,257	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,140,890	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	6,027,988	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,589,135	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	7,112,352	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,112,352	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15,701,487	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	28,815,379				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)	28,815,379	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	44,516,866	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet G-1 | Date/Time Prepared: 8/31/2023 10:00 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		27,352,594		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,441,057				2.00
3.00	Total (sum of line 1 and line 2)		28,793,651		0		3.00
4.00	NON OPER EQUITY	21,765		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)		21,765		0		10.00
11.00	Subtotal (line 3 plus line 10)		28,815,416		0		11.00
12.00	NTB	37		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)		37		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		28,815,379		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	NON OPER EQUITY		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	NTB		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: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/31/2023 10:00 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,858,002		1,858,002	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	119,061		119,061	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,977,063		1,977,063	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,977,063		1,977,063	17.00
18.00	Ancillary services	3,359,223	39,101,487	42,460,710	18.00
19.00	Outpatient services	0	2	2	19.00
20.00	RURAL HEALTH CLINIC (MMC)	0	825,182	825,182	20.00
20.01	RURAL HEALTH CLINIC (FCC)	0	841,265	841,265	20.01
20.02	RURAL HEALTH CLINIC (ICC)	0	578,035	578,035	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	2,189,650	2,189,650	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,336,286	43,535,621	48,871,907	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		29,399,399		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		29,399,399		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1323 | Period: From 04/01/2022 To 03/31/2023 | Worksheet G-3 | Date/Time Prepared: 8/31/2023 10:00 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	48,871,907	1.00
2.00	Less contractual allowances and discounts on patients' accounts	21,575,543	2.00
3.00	Net patient revenues (line 1 minus line 2)	27,296,364	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	29,399,399	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,103,035	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,041,912	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	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	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	1,155,900	24.00
24.01	OTHER NONOPERATING REVENUE	527,310	24.01
24.50	COVID-19 PHE Funding	818,970	24.50
25.00	Total other income (sum of lines 6-24)	3,544,092	25.00
26.00	Total (line 5 plus line 25)	1,441,057	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,441,057	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323 | Component CCN: 14-3478 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-1 | Date/Time Prepared: 8/31/2023 10:00 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	184,562	0	184,562	0	184,562	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	149,937	0	149,937	0	149,937	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	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)	334,499	0	334,499	0	334,499	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	10,910	10,910	0	10,910	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	145,741	145,741	0	145,741	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	156,651	156,651	0	156,651	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	334,499	156,651	491,150	0	491,150	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	16,232	16,232	0	16,232	29.00
30.00	Administrative Costs	320,641	18,882	339,523	0	339,523	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	320,641	35,114	355,755	0	355,755	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	655,140	191,765	846,905	0	846,905	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323 | Component CCN: 14-3478 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-1 | Date/Time Prepared: 8/31/2023 10:00 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	184,562		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	149,937		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	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	334,499		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	10,910		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	-21,069	124,672		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	-21,069	135,582		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-21,069	470,081		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	16,232		29.00
30.00	Administrative Costs	0	339,523		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	355,755		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-21,069	825,836		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323 | Component CCN: 14-8598 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-1 | Date/Time Prepared: 8/31/2023 10:00 am

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	293,821	0	293,821	0	293,821	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	194,827	0	194,827	0	194,827	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	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)	488,648	0	488,648	0	488,648	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	6,379	6,379	0	6,379	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	46,213	46,213	0	46,213	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	52,592	52,592	0	52,592	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	488,648	52,592	541,240	0	541,240	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	33,812	33,812	0	33,812	29.00
30.00	Administrative Costs	242,269	51,751	294,020	0	294,020	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	242,269	85,563	327,832	0	327,832	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	730,917	138,155	869,072	0	869,072	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323 | Component CCN: 14-8598 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-1 | Date/Time Prepared: 8/31/2023 10:00 am

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	293,821		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	194,827		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	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	488,648		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	6,379		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	46,213		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	52,592		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	541,240		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	33,812		29.00
30.00	Administrative Costs	-46,902	247,118		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-46,902	280,930		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-46,902	822,170		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323 | Component CCN: 14-8618 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-1 | Date/Time Prepared: 8/31/2023 10:00 am

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	394,357	0	394,357	0	394,357	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	98,702	0	98,702	0	98,702	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	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)	493,059	0	493,059	0	493,059	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	3,837	3,837	0	3,837	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	16,726	16,726	0	16,726	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	20,563	20,563	0	20,563	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	493,059	20,563	513,622	0	513,622	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	3,082	3,082	0	3,082	29.00
30.00	Administrative Costs	160,663	34,342	195,005	0	195,005	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	160,663	37,424	198,087	0	198,087	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	653,722	57,987	711,709	0	711,709	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323 | Component CCN: 14-8618 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-1 | Date/Time Prepared: 8/31/2023 10:00 am

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	394,357		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	98,702		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	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	493,059		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	3,837		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	-10,785	5,941		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	-10,785	9,778		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-10,785	502,837		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	3,082		29.00
30.00	Administrative Costs	0	195,005		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	198,087		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-10,785	700,924		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1323 | Component CCN: 14-3478 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-2 | Date/Time Prepared: 8/31/2023 10:00 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.61	3,294	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.15	3,294	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.76	6,588		2	6,588	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.76	6,588			6,588	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)					470,081	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)					470,081	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)					355,755	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					986,293	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,342,048	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,342,048	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,342,048	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,812,129	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1323 | Component CCN: 14-8598 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-2 | Date/Time Prepared: 8/31/2023 10:00 am

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	0.57	3,256	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.28	2,877	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.85	6,133		2	6,133	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.85	6,133			6,133	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)					541,240	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)					541,240	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)					280,930	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,100,386	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,381,316	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,381,316	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,381,316	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,922,556	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1323 | Component CCN: 14-8618 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-2 | Date/Time Prepared: 8/31/2023 10:00 am

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	1.05	1,936	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.55	2,039	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.60	3,975		2	3,975	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.60	3,975			3,975	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)					502,837	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)					502,837	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)					198,087	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					743,552	15.00
16.00	Total overhead (sum of lines 14 and 15)					941,639	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					941,639	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					941,639	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,444,476	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1323 Component CCN: 14-3478	Period: From 04/01/2022 To 03/31/2023	Worksheet M-3 Date/Time Prepared: 8/31/2023 10:00 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,812,129	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			22,956	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,789,173	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,588	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)			6,588	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			271.58	7.00
		Calculation of Limit (1)			
		Rate Period 1 (04/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 03/31/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	269.28	279.50		8.00
9.00	Rate for Program covered visits (see instructions)	269.28	271.58		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	889	495		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	239,390	134,432		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	373,822		16.00
16.01	Total program charges (see instructions)(from contractor's records)		183,053		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		11,267		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		23,009		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.)		262,929		16.04
16.05	Total program cost (see instructions)	0	285,938		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		22,152		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		21,749		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		285,938		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,915		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		292,853		22.00
23.00	Allowable bad debts (see instructions)		62,504		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		40,628		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		45,373		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)		333,481		26.00
26.01	Sequestration adjustment (see instructions)		5,836		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		215,732		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)		111,913		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: 14-1323 Component CCN: 14-8598	Period: From 04/01/2022 To 03/31/2023	Worksheet M-3 Date/Time Prepared: 8/31/2023 10:00 am
	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)			1,922,556	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			28,750	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,893,806	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,133	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)			6,133	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			308.79	7.00
		Calculation of Limit (1)			
		Rate Period 1 (04/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 03/31/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	306.32	317.96		8.00
9.00	Rate for Program covered visits (see instructions)	306.32	308.79		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	897	602		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	274,769	185,892		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	460,661		16.00
16.01	Total program charges (see instructions)(from contractor's records)		206,232		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		16,203		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		36,193		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.)		316,678		16.04
16.05	Total program cost (see instructions)	0	352,871		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		28,621		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		35,522		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		352,871		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		10,716		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		363,587		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		363,587		26.00
26.01	Sequestration adjustment (see instructions)		6,363		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		319,383		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)		37,841		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: 14-1323 Component CCN: 14-8618	Period: From 04/01/2022 To 03/31/2023	Worksheet M-3 Date/Time Prepared: 8/31/2023 10:00 am
	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)			1,444,476	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			25,883	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,418,593	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,975	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)			3,975	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			356.88	7.00
		Calculation of Limit (1)			
		Rate Period 1 (04/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 03/31/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	282.50	282.50		8.00
9.00	Rate for Program covered visits (see instructions)	282.50	282.50		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	631	211		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	178,258	59,608		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	237,866		16.00
16.01	Total program charges (see instructions)(from contractor's records)		111,164		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,223		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		9,036		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.)		174,080		16.04
16.05	Total program cost (see instructions)	0	183,116		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		11,230		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		19,805		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		183,116		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,065		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		188,181		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		188,181		26.00
26.01	Sequestration adjustment (see instructions)		3,293		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		203,050		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)		-18,162		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: 14-1323 | Component CCN: 14-3478 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-4 | Date/Time Prepared: 8/31/2023 10:00 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	334,499	334,499	334,499	334,499	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001855	0.008230	0.006810	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	620	2,753	2,278	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	243	61	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	863	2,814	2,278	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	470,081	470,081	470,081	470,081	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,342,048	1,342,048	1,342,048	1,342,048	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.001836	0.005986	0.004846	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2,464	8,033	6,504	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	3,327	10,847	8,782	0	10.00
11.00	Total number of injections/infusions (from your records)	4	68	3	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	831.75	159.51	2,927.33	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	25	1	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	3,988	2,927	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)		22,956	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)		6,915	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1323 | Component CCN: 14-8598 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-4 | Date/Time Prepared: 8/31/2023 10:00 am

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)	488,648	488,648	488,648	488,648	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001801	0.006880	0.007260	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	880	3,362	3,548	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	243	61	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,123	3,423	3,548	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	541,240	541,240	541,240	541,240	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,381,316	1,381,316	1,381,316	1,381,316	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.002075	0.006324	0.006555	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2,866	8,735	9,055	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	3,989	12,158	12,603	0	10.00
11.00	Total number of injections/infusions (from your records)	24	372	128	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	166.21	32.68	98.46	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	2	140	59	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)	332	4,575	5,809	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)		28,750	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)		10,716	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1323 | Component CCN: 14-8618 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-4 | Date/Time Prepared: 8/31/2023 10:00 am

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)	493,059	493,059	493,059	493,059	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001722	0.007955	0.007980	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	849	3,922	3,935	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	243	61	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,092	3,983	3,935	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	502,837	502,837	502,837	502,837	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	941,639	941,639	941,639	941,639	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.002172	0.007921	0.007826	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2,045	7,459	7,369	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	3,137	11,442	11,304	0	10.00
11.00	Total number of injections/infusions (from your records)	4	72	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	784.25	158.92	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	2	22	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)	1,569	3,496	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)		25,883	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)		5,065	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1323 Component CCN: 14-3478	Period: From 04/01/2022 To 03/31/2023	Worksheet M-5 Date/Time Prepared: 8/31/2023 10:00 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		188,290	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		10/17/2022	18,607	3.01
3.02		03/02/2023	8,835	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)		27,442	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		215,732	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		111,913	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		327,645	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	CGS	15101		8.00

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

Provider CCN: 14-1323 | Component CCN: 14-8598 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-5 | Date/Time Prepared: 8/31/2023 10:00 am

RHC II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		297,311	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		10/17/2023	3,765	3.01
3.02		03/02/2023	18,307	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)		22,072	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		319,383	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		37,841	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		357,224	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	CGS	15101		8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1323 Component CCN: 14-8618	Period: From 04/01/2022 To 03/31/2023	Worksheet M-5 Date/Time Prepared: 8/31/2023 10:00 am
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		127,704	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		10/17/2022	20,177	3.01
3.02		03/02/2023	55,169	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)		75,346	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		203,050	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		18,162	6.02
7.00	Total Medicare program liability (see instructions)		184,888	7.00

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