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: 14-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet S Parts I-III Date/Time Prepared: 11/20/2023 11:03 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/20/2023 Time: 11:03 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by KIRBY HOSPITAL (14-1301) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Kimberly Alvis		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	Kimberly Alvis			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	34,014	-374,390	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	42,531	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		68,817		0	10.00
10.01	RURAL HEALTH CLINIC II	0		27,544		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-25,826		0	10.02
200.00	TOTAL	0	76,545	-303,855	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: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2023 11:03 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 MEDICAL CENTER DRIVE	PO Box:			1.00
2.00	City: MONTICELLO	State: IL	Zip Code: 61856	County: PIATT	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	KIRBY HOSPITAL	141301	16580	1	08/08/1999	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	KIRBY HOSPITAL - SWING BED	14Z301	16580		08/08/1999	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	ATWOOD RURAL HEALTH CLINIC	143438	16580		11/17/1997	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	KIRBY MEDICAL GROUP RHC	143495	16580		11/20/2008	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	CERRO GORDO RURAL HEALTH CLINIC	148566	16580		12/29/2016	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)	07/01/2022	06/30/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2023 11:03 am

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

		Urban/Rural 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.	1		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.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/20/2023 11:03 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2023 11:03 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2023 11:03 am

					1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)					
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?				N	68.00
			1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
					1.00	
	Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00
	TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.				N	87.00
				Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
				1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.				0	88.00
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
			1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.		0.00		0	89.00
				V	XIX	
				1.00	2.00	
	Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	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

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		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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

		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.	2			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2023 11:03 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	127,789	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2023 11:03 am

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/20/2023 11:03 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		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/09/2023	Y	10/09/2023	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: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II Date/Time Prepared: 11/20/2023 11:03 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.	Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	Y	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.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part II Date/Time Prepared: 11/20/2023 11:03 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.	SIGNING DIRECTOR, REIMBURSEMENT		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: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 11/20/2023 11:03 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	16	5,840	14,232.00	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)		16	5,840	14,232.00	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)		16	5,840	14,232.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		16				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: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2023 11:03 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)	199	1	593			1.00
2.00	HMO and other (see instructions)	279	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	536	0	1,029			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	180			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	735	1	1,802			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)	735	1	1,802	0.00	232.81	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	626	0	4,029	0.00	7.05	26.00
26.01	RURAL HEALTH CLINIC II	2,495	0	22,551	0.00	45.97	26.01
26.02	RURAL HEALTH CLINIC III	878	0	4,296	0.00	7.83	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	293.66	27.00
28.00	Observation Bed Days		0	383			28.00
29.00	Ambulance Trips	540					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: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2023 11:03 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	66	1	174	1.00
2.00	HMO and other (see instructions)			78	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	66	1	174	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	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: 14-1301 | Component CCN: 14-3438 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 11/20/2023 11:03 am

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	108 SOUTH MAIN STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	ATWOOD	IL	61913	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	16:30	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		DOUGLAS				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1301 | Component CCN: 14-3438 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 11/20/2023 11:03 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: 14-1301 | Component CCN: 14-3495 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 11/20/2023 11:03 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1000 MEDICAL CENTER DRIVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MONTICELLO		IL	61856	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			07:00	18:00	07:00	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		PIATT				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	18:00	07:00	18:00	07:00	18:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1301 Component CCN: 14-3495	Period: From 07/01/2022 To 06/30/2023	Worksheet S-8 Date/Time Prepared: 11/20/2023 11:03 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	07:00	16:00	08:00	12:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1301 | Component CCN: 14-8566 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 11/20/2023 11:03 am

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			407 S. JACKSON STREET, SUITE A		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CERRO GORDO		IL	61818	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			07:00	17:30	07:00	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		PIATT				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:00	17:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1301 Component CCN: 14-8566	Period: From 07/01/2022 To 06/30/2023	Worksheet S-8 Date/Time Prepared: 11/20/2023 11:03 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	07:00	16:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-10 | Date/Time Prepared: 11/20/2023 11:03 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)	0.375944	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,680,711	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	18,292,518	6.00
7.00	Medicaid cost (line 1 times line 6)	6,876,962	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)	1,196,251	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	19,377	9.00
10.00	Stand-alone CHIP charges	27,937	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	10,503	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)	1,196,251	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)	1,470,919	0	1,470,919	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	552,983	0	552,983	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)	552,983	0	552,983	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,179,269	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	208,599	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	320,921	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,858,348	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,186,901	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,739,884	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,936,135	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/20/2023 11:03 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		3,769,766	3,769,766	-94,578	3,675,188	1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING		0	0	176,266	176,266	1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING		0	0	87,944	87,944	1.02
1.03	00103	CROSSFIT BUILDING		0	0	52,013	52,013	1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE		0	0	14,579	14,579	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,475,908	1,475,908	48,334	1,524,242	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	156,472	274,023	430,495	87,361	517,856	4.00
5.01	00540	PFS & REGISTRATION	1,176,993	1,234,462	2,411,455	878,410	3,289,865	5.01
5.02	00550	ADMINISTRATIVE & GENERAL	3,085,584	6,396,807	9,482,391	-683,438	8,798,953	5.02
6.00	00600	MAINTENANCE & REPAIRS	394,587	880,726	1,275,313	0	1,275,313	6.00
7.00	00700	OPERATION OF PLANT	0	492,156	492,156	-155,677	336,479	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	65,133	65,133	0	65,133	8.00
9.00	00900	HOUSEKEEPING	474,903	278,512	753,415	0	753,415	9.00
10.00	01000	DIETARY	691,425	583,209	1,274,634	-1,024,750	249,884	10.00
11.00	01100	CAFETERIA	0	0	0	1,001,413	1,001,413	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	227,152	93,151	320,303	-193	320,110	14.00
15.00	01500	PHARMACY	211,500	819,567	1,031,067	-552,174	478,893	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	922,328	706,955	1,629,283	47,827	1,677,110	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	461,640	48,733	510,373	0	510,373	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,517,299	1,370,983	2,888,282	104,133	2,992,415	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	856,926	3,199,999	4,056,925	-938,325	3,118,600	50.00
53.00	05300	ANESTHESIOLOGY	0	837,411	837,411	0	837,411	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,173,899	1,981,236	3,155,135	97,132	3,252,267	54.00
60.00	06000	LABORATORY	711,816	1,791,025	2,502,841	86,561	2,589,402	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	812,467	688,616	1,501,083	-196,076	1,305,007	66.00
67.00	06700	OCCUPATIONAL THERAPY	183,632	75,793	259,425	0	259,425	67.00
68.00	06800	SPEECH PATHOLOGY	30,374	3,856	34,230	0	34,230	68.00
69.00	06900	ELECTROCARDIOLOGY	0	32,204	32,204	19,937	52,141	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	533,732	533,732	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	554,171	554,171	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	573,971	573,971	73.00
76.00	03950	SLEEP LAB	142,711	115,661	258,372	550	258,922	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	41,250	458,051	499,301	-1,706	497,595	76.02
76.03	03030	WOUNDCARE	18,668	137,383	156,051	-4,379	151,672	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	672,151	408,074	1,080,225	-88,781	991,444	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,908,001	2,354,338	6,262,339	-484,507	5,777,832	88.01
88.02	08802	RURAL HEALTH CLINIC III	688,617	394,387	1,083,004	-156,571	926,433	88.02
91.00	09100	EMERGENCY	1,823,320	3,969,500	5,792,820	-165,396	5,627,424	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	382,603	294,709	677,312	155,115	832,427	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,766,318	35,232,334	55,998,652	-27,102	55,971,550	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	99,505	99,505	-1,700	97,805	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	546,317	2,554,404	3,100,721	1,426	3,102,147	194.00
194.01	07951	FOUNDATION	83,142	86,899	170,041	0	170,041	194.01
194.02	07952	CROSSFIT	165,060	130,370	295,430	27,376	322,806	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	21,560,837	38,103,512	59,664,349	0	59,664,349	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/20/2023 11:03 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	-588,395	3,086,793		1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING	0	176,266		1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING	0	87,944		1.02
1.03	00103	CROSSFIT BUILDING	0	52,013		1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE	0	14,579		1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-64,116	1,460,126		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	517,856		4.00
5.01	00540	PFS & REGISTRATION	0	3,289,865		5.01
5.02	00550	ADMINISTRATIVE & GENERAL	-1,805,865	6,993,088		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	1,275,313		6.00
7.00	00700	OPERATION OF PLANT	0	336,479		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	65,133		8.00
9.00	00900	HOUSEKEEPING	0	753,415		9.00
10.00	01000	DIETARY	-793	249,091		10.00
11.00	01100	CAFETERIA	-198,877	802,536		11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	320,110		14.00
15.00	01500	PHARMACY	0	478,893		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-80	1,677,030		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-510,373	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-608,815	2,383,600		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,118,600		50.00
53.00	05300	ANESTHESIOLOGY	-784,320	53,091		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-547,909	2,704,358		54.00
60.00	06000	LABORATORY	-23,977	2,565,425		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	-43,713	1,261,294		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	259,425		67.00
68.00	06800	SPEECH PATHOLOGY	0	34,230		68.00
69.00	06900	ELECTROCARDIOLOGY	-30,525	21,616		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	533,732		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	554,171		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	573,971		73.00
76.00	03950	SLEEP LAB	-33,586	225,336		76.00
76.01	03951	DIABETIC EDUCATION	0	0		76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	497,595		76.02
76.03	03030	WOUNDCARE	0	151,672		76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-126	991,318		88.00
88.01	08801	RURAL HEALTH CLINIC II	-457,514	5,320,318		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	926,433		88.02
91.00	09100	EMERGENCY	-1,616,995	4,010,429		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-63,278	769,149		95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-7,379,257	48,592,293		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	97,805		192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	0	3,102,147		194.00
194.01	07951	FOUNDATION	0	170,041		194.01
194.02	07952	CROSSFIT	0	322,806		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-7,379,257	52,285,092		200.00

RECLASSIFICATIONS | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/20/2023 11:03 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	115,908		1.00
	0		0	115,908		
	B - INTEREST					
1.00	RETAIL PHARMACIES - KIRBY & CERRO	194.00	0	8,603		1.00
	TOTALS		0	8,603		
	C - CAFETERIA					
1.00	CAFETERIA	11.00	543,017	458,396		1.00
2.00	RURAL HEALTH CLINIC II	88.01	850	250		2.00
	0		543,867	458,646		
	D - EKG					
1.00	ELECTROCARDIOLOGY	69.00	15,028	4,909		1.00
2.00		0.00	0	0		2.00
	0		15,028	4,909		
	E - RHC ADMITTING					
1.00	PFS & REGISTRATION	5.01	651,961	174,938		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	2,133	562		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		654,094	175,500		
	G - CROSSFIT EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	11,605	12,808		1.00
	0		11,605	12,808		
	H - WORKERS' COMP INS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	62,948		1.00
	0		0	62,948		
	I - TELEPHONE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.02	0	187,339		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
	0		0	187,339		
	K - MEDICAL SUPPLIES, IMPLANTS & DRUGS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	510,103		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	554,171		2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	552,174		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
	0		0	1,616,448		
	L - AMBULANCE SALARY					
1.00	AMBULANCE SERVICES	95.00	121,028	38,315		1.00
	0		121,028	38,315		
	N - DEPRECIATION EXPENSE RECLASS					
1.00	RURAL HEALTH CLINIC I BUILDING	1.01	0	172,382		1.00
2.00	RURAL HEALTH CLINIC III BUILDING	1.02	0	85,974		2.00
3.00	CROSSFIT BUILDING	1.03	0	50,809		3.00
4.00	AMBULANCE/MAINTENANCE GARAGE	1.04	0	14,100		4.00
	0		0	323,265		
	O - BOND RELATED COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	177,253		1.00
	0		0	177,253		
	S - MOB EXPENSE					
1.00	PFS & REGISTRATION	5.01	0	27,882		1.00
2.00	ADMINISTRATIVE & GENERAL	5.02	0	20,191		2.00
	TOTALS		0	48,073		
	T - WOUND CARE IN MOB					
1.00	WOUNDCARE	76.03	0	2,395		1.00
	TOTALS		0	2,395		
	V - DIETICIANS IN A&P					
1.00	ADULTS & PEDIATRICS	30.00	18,697	5,505		1.00
	TOTALS		18,697	5,505		
	W - IT AND CLINICAL INFORMATICS					
1.00	PFS & REGISTRATION	5.01	0	23,629		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	97,900		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	103,638		3.00

RECLASSIFICATIONS | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/20/2023 11:03 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
4.00	OPERATING ROOM	50.00	0	32,099	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	103,375	5.00
6.00	LABORATORY	60.00	0	86,561	6.00
7.00	PHYSICAL THERAPY	66.00	0	3,461	7.00
8.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	23,629	8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	21,797	9.00
10.00	SLEEP LAB	76.00	0	550	10.00
11.00	SENIOR LIFE SOLUTIONS	76.02	0	294	11.00
12.00	WOUNDCARE	76.03	0	337	12.00
13.00	RURAL HEALTH CLINIC	88.00	0	13,910	13.00
14.00	RURAL HEALTH CLINIC II	88.01	0	81,229	14.00
15.00	RURAL HEALTH CLINIC III	88.02	0	14,870	15.00
16.00	EMERGENCY	91.00	0	71,337	16.00
17.00	AMBULANCE SERVICES	95.00	0	2,026	17.00
	TOTALS		0	680,642	
	X - THERAPY AND WELLNESS				
1.00	ADMINISTRATIVE & GENERAL	5.02	0	145,783	1.00
2.00	DIETARY	10.00	0	1,965	2.00
3.00	CROSSFIT	194.02	0	51,789	3.00
	TOTALS		0	199,537	
500.00	Grand Total: Increases		1,364,319	4,118,094	500.00

RECLASSIFICATIONS | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/20/2023 11:03 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.02	0	115,908	12		1.00
	0		0	115,908			
	B - INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,603	11		1.00
	TOTALS		0	8,603			
	C - CAFETERIA						
1.00	DIETARY	10.00	543,867	458,646	0		1.00
2.00		0.00	0	0	0		2.00
	0		543,867	458,646			
	D - EKG						
1.00	EMERGENCY	91.00	10,401	3,293	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	4,627	1,616	0		2.00
	0		15,028	4,909			
	E - RHC ADMITTING						
1.00	RURAL HEALTH CLINIC	88.00	75,398	23,596	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	448,701	118,135	0		2.00
3.00	RURAL HEALTH CLINIC III	88.02	124,957	31,696	0		3.00
4.00	WOUNDCARE	76.03	5,038	2,073	0		4.00
	0		654,094	175,500			
	G - CROSSFIT EMPLOYEE BENEFITS						
1.00	CROSSFIT	194.02	11,605	12,808	0		1.00
	0		11,605	12,808			
	H - WORKERS' COMP INS						
1.00	ADMINISTRATIVE & GENERAL	5.02	0	62,948	0		1.00
	0		0	62,948			
	I - TELEPHONE EXPENSE						
1.00	OPERATION OF PLANT	7.00	0	155,677	0		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,000	0		2.00
3.00	SENIOR LIFE SOLUTIONS	76.02	0	2,000	0		3.00
4.00	RURAL HEALTH CLINIC	88.00	0	3,697	0		4.00
5.00	RURAL HEALTH CLINIC III	88.02	0	14,788	0		5.00
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,000	0		6.00
7.00	RETAIL PHARMACIES - KIRBY & CERRO	194.00	0	7,177	0		7.00
	0		0	187,339			
	K - MEDICAL SUPPLIES, IMPLANTS & DRUGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	193	0		1.00
2.00	PHARMACY	15.00	0	552,174	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	23,707	0		3.00
4.00	OPERATING ROOM	50.00	0	970,424	0		4.00
5.00	EMERGENCY	91.00	0	63,696	0		5.00
6.00	AMBULANCE SERVICES	95.00	0	6,254	0		6.00
	0		0	1,616,448			
	L - AMBULANCE SALARY						
1.00	EMERGENCY	91.00	121,028	38,315	0		1.00
	0		121,028	38,315			
	N - DEPRECIATION EXPENSE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	323,265	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
4.00		0.00	0	0	9		4.00
	0		0	323,265			
	O - BOND RELATED COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.02	0	177,253	14		1.00
	0		0	177,253			
	S - MOB EXPENSE						
1.00	MEDICAL RECORDS & LIBRARY	16.00	0	48,073	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	48,073			
	T - WOUND CARE IN MOB						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,395	0		1.00
	TOTALS		0	2,395			
	V - DIETICIANS IN A&P						
1.00	DIETARY	10.00	18,697	5,505	0		1.00
	TOTALS		18,697	5,505			
	W - IT AND CLINICAL INFORMATICS						
1.00	ADMINISTRATIVE & GENERAL	5.02	0	680,642	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00

RECLASSIFICATIONS | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/20/2023 11:03 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
	TOTALS		0	680,642			
	X - THERAPY AND WELLNESS						
1.00	PHYSICAL THERAPY	66.00	0	199,537	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	199,537			
500.00	Grand Total: Decreases		1,364,319	4,118,094			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 11/20/2023 11:03 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	465,106	52,168	0	52,168	0	1.00
2.00	Land Improvements	7,360,718	1,794,272	0	1,794,272	0	2.00
3.00	Buildings and Fixtures	30,927,614	9,698,694	0	9,698,694	1,058,556	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	295,404	208,053	0	208,053	0	5.00
6.00	Movable Equipment	17,089,630	4,538,913	0	4,538,913	0	6.00
7.00	HIT designated Assets	13,117,695	2,216,674	0	2,216,674	1,371,894	7.00
8.00	Subtotal (sum of lines 1-7)	69,256,167	18,508,774	0	18,508,774	2,430,450	8.00
9.00	Reconciling Items	-3,834,496	4,270,527	0	4,270,527	0	9.00
10.00	Total (line 8 minus line 9)	73,090,663	14,238,247	0	14,238,247	2,430,450	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	517,274	0	1.00
2.00	Land Improvements	9,154,990	0	2.00
3.00	Buildings and Fixtures	39,567,752	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	503,457	0	5.00
6.00	Movable Equipment	21,628,543	0	6.00
7.00	HIT designated Assets	13,962,475	0	7.00
8.00	Subtotal (sum of lines 1-7)	85,334,491	0	8.00
9.00	Reconciling Items	436,031	0	9.00
10.00	Total (line 8 minus line 9)	84,898,460	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 11/20/2023 11:03 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	2,781,736	0	988,030	0	0	1.00
1.01	RURAL HEALTH CLINIC I BUILDING	0	0	0	0	0	1.01
1.02	RURAL HEALTH CLINIC III BUILDING	0	0	0	0	0	1.02
1.03	CROSSFIT BUILDING	0	0	0	0	0	1.03
1.04	AMBULANCE/MAINTENANCE GARAGE	0	0	0	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	1,475,908	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,257,644	0	988,030	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	3,769,766	1.00
1.01	RURAL HEALTH CLINIC I BUILDING	0	0	1.01
1.02	RURAL HEALTH CLINIC III BUILDING	0	0	1.02
1.03	CROSSFIT BUILDING	0	0	1.03
1.04	AMBULANCE/MAINTENANCE GARAGE	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,475,908	2.00
3.00	Total (sum of lines 1-2)	0	5,245,674	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 11/20/2023 11:03 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	44,195,626	0	44,195,626	0.517977	60,037	1.00
1.01	RURAL HEALTH CLINIC I BUILDING	2,859,062	0	2,859,062	0.033509	3,884	1.01
1.02	RURAL HEALTH CLINIC III BUILDING	1,450,048	0	1,450,048	0.016995	1,970	1.02
1.03	CROSSFIT BUILDING	886,241	0	886,241	0.010387	1,204	1.03
1.04	AMBULANCE/MAINTENANCE GARAGE	352,496	0	352,496	0.004131	479	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	35,591,018	11,039	35,579,979	0.417001	48,334	2.00
3.00	Total (sum of lines 1-2)	85,334,491	11,039	85,323,452	1.000000	115,908	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	60,037	2,407,866	0	1.00
1.01	RURAL HEALTH CLINIC I BUILDING	0	0	3,884	172,382	0	1.01
1.02	RURAL HEALTH CLINIC III BUILDING	0	0	1,970	85,974	0	1.02
1.03	CROSSFIT BUILDING	0	0	1,204	50,809	0	1.03
1.04	AMBULANCE/MAINTENANCE GARAGE	0	0	479	14,100	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	48,334	1,411,792	0	2.00
3.00	Total (sum of lines 1-2)	0	0	115,908	4,142,923	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	441,637	60,037	0	177,253	3,086,793	1.00
1.01	RURAL HEALTH CLINIC I BUILDING	0	3,884	0	0	176,266	1.01
1.02	RURAL HEALTH CLINIC III BUILDING	0	1,970	0	0	87,944	1.02
1.03	CROSSFIT BUILDING	0	1,204	0	0	52,013	1.03
1.04	AMBULANCE/MAINTENANCE GARAGE	0	479	0	0	14,579	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	48,334	0	0	1,460,126	2.00
3.00	Total (sum of lines 1-2)	441,637	115,908	0	177,253	4,877,721	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/20/2023 11:03 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	-537,790	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - RURAL HEALTH CLINIC I BUILDING (chapter 2)		0	RURAL HEALTH CLINIC I BUILDING	1.01	0	1.01
1.02	Investment income - RURAL HEALTH CLINIC III BUILDING (chapter 2)		0	RURAL HEALTH CLINIC III BUILDING	1.02	0	1.02
1.03	Investment income - CROSSFIT BUILDING (chapter 2)		0	CROSSFIT BUILDING	1.03	0	1.03
1.04	Investment income - AMBULANCE/MAINTENANCE GARAGE (chapter 2)		0	AMBULANCE/MAINTENANCE GARAGE	1.04	0	1.04
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,393	ADMINISTRATIVE & GENERAL	5.02	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	-3,647,664			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-198,877	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-58	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	*** Cost Center Deleted ***	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 - RURAL HEALTH CLINIC I BUILDING		0	RURAL HEALTH CLINIC I BUILDING	1.01	0	26.01
26.02	Depreciation - RURAL HEALTH CLINIC III BUILDING		0	RURAL HEALTH CLINIC III BUILDING	1.02	0	26.02

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/20/2023 11:03 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	
26.03	Depreciation - CROSSFIT BUILDING		0	CROSSFIT BUILDING	1.03	0	26.03
26.04	Depreciation - AMBULANCE/MAINTENANCE GARAGE		0	AMBULANCE/MAINTENANCE GARAGE	1.04	0	26.04
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-510,373	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-45,075	ADMINISTRATIVE & GENERAL	5.02	0	33.00
33.01	AMBULANCE INCOME	B	-63,278	AMBULANCE SERVICES	95.00	0	33.01
33.02	CANCER CLINIC INCOME	B	-5,863	ADMINISTRATIVE & GENERAL	5.02	0	33.02
33.03	PHASE III CARDIAC REHAB INCOME	B	-42,156	PHYSICAL THERAPY	66.00	0	33.03
33.04	NON-ALLOWABLE ADVERTISING	A	-342,360	ADMINISTRATIVE & GENERAL	5.02	0	33.04
33.05	NON-ALLOWABLE LOBBYING	A	-12,340	ADMINISTRATIVE & GENERAL	5.02	0	33.05
33.06	PROPERTY TAX	A	-130	ADMINISTRATIVE & GENERAL	5.02	0	33.06
33.07	MEDICAID ASSESSMENT TAX	A	-1,035,697	ADMINISTRATIVE & GENERAL	5.02	0	33.07
33.08	KEY EMPLOYEE LIFE INSURANCE	A	-22,150	ADMINISTRATIVE & GENERAL	5.02	0	33.08
33.09	TIF EXPENSE NOT RELATED TO THE HOSPI	A	-121,109	ADMINISTRATIVE & GENERAL	5.02	0	33.09
33.10	NON-ALLOWABLE DONATION EXPENSE	A	-217,178	ADMINISTRATIVE & GENERAL	5.02	0	33.10
33.11	MISC REVENUE - DIETARY	B	-793	DIETARY	10.00	0	33.11
33.12	TELEPHONE DEPRECIATION	A	-95	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.12
34.00	MISC EXPENSE - A&G	A	-2,570	ADMINISTRATIVE & GENERAL	5.02	0	34.00
34.01	MISC EXPENSE - MED RECORDS	A	-22	MEDICAL RECORDS & LIBRARY	16.00	0	34.01
34.02	MISC EXPENSE - RHC I	A	-126	RURAL HEALTH CLINIC	88.00	0	34.02
34.03	MISC EXPENSE - RHC II	A	-619	RURAL HEALTH CLINIC II	88.01	0	34.03
34.04	MISC EXPENSE - ANESTHESIA	A	-20	ANESTHESIOLOGY	53.00	0	34.04
35.00	WELLNESS TRAIL DEPRECIATION EXPENSE	A	-50,605	CAP REL COSTS-BLDG & FIXT	1.00	9	35.00
36.00	KMH RHC PROFESSIONAL FEES	A	-456,895	RURAL HEALTH CLINIC II	88.01	0	36.00
37.00	GOODWILL AMORTIZATION	A	-64,021	CAP REL COSTS-MVBLE EQUIP	2.00	9	37.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,379,257				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: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 11/20/2023 11:03 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	608,815	608,815	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	784,300	784,300	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	547,909	547,909	0	0	0	3.00
4.00	60.00	LABORATORY	23,977	23,977	0	0	0	4.00
5.00	66.00	PHYSICAL THERAPY	1,557	1,557	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	30,525	30,525	0	0	0	6.00
7.00	76.00	SLEEP LAB	33,586	33,586	0	0	0	7.00
8.00	91.00	EMERGENCY	2,683,758	1,616,995	1,066,763	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			4,714,427	3,647,664	1,066,763		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	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	76.00	SLEEP LAB	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	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	608,815		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	784,300		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	547,909		3.00
4.00	60.00	LABORATORY	0	0	0	23,977		4.00
5.00	66.00	PHYSICAL THERAPY	0	0	0	1,557		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	30,525		6.00
7.00	76.00	SLEEP LAB	0	0	0	33,586		7.00
8.00	91.00	EMERGENCY	0	0	0	1,616,995		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	3,647,664		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/20/2023 11:03 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	RURAL HEALTH CLINIC I BUILDING	RURAL HEALTH CLINIC III BUILDING	CROSSFIT BUILDING	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,086,793	3,086,793				1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING	176,266	0	176,266			1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING	87,944	0	0	87,944		1.02
1.03	00103	CROSSFIT BUILDING	52,013	0	0	0	52,013	1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE	14,579	0	0	0	0	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,460,126					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	517,856	4,004	0	0	0	4.00
5.01	00540	PFS & REGISTRATION	3,289,865	41,402	3,687	1,049	0	5.01
5.02	00550	ADMINISTRATIVE & GENERAL	6,993,088	296,581	0	0	17,338	5.02
6.00	00600	MAINTENANCE & REPAIRS	1,275,313	9,486	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	336,479	587,680	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	65,133	11,974	0	0	0	8.00
9.00	00900	HOUSEKEEPING	753,415	31,023	0	0	0	9.00
10.00	01000	DIETARY	249,091	96,100	0	0	0	10.00
11.00	01100	CAFETERIA	802,536	43,813	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	320,110	65,350	0	0	0	14.00
15.00	01500	PHARMACY	478,893	24,608	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,677,030	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,383,600	354,350	0	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,118,600	304,551	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	53,091	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,704,358	164,560	8,768	0	0	54.00
60.00	06000	LABORATORY	2,565,425	90,735	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,261,294	110,057	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	259,425	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	34,230	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	21,616	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	533,732	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	554,171	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	573,971	0	0	0	0	73.00
76.00	03950	SLEEP LAB	225,336	12,868	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	497,595	0	0	0	0	76.02
76.03	03030	WOUNDCARE	151,672	0	0	0	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	991,318	0	163,811	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,320,318	541,497	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	926,433	0	0	59,516	0	88.02
91.00	09100	EMERGENCY	4,010,429	241,184	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	769,149	29,895	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,592,293	3,061,718	176,266	60,565	17,338	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,479	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	97,805	0	0	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	3,102,147	8,864	0	27,379	0	194.00
194.01	07951	FOUNDATION	170,041	3,732	0	0	0	194.01
194.02	07952	CROSSFIT	322,806	0	0	0	34,675	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	52,285,092	3,086,793	176,266	87,944	52,013	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/20/2023 11:03 am

		Cost Center Description	CAPITAL RELATED COSTS					
			AMBULANCE/MAINTENANCE GARAGE	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	PFS & REGISTRATION	Subtotal	
			1.04	2.00	4.00	5.01	5A.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE	14,579					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,460,126				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	322	522,182			4.00
5.01	00540	PFS & REGISTRATION	0	0	45,629	3,381,632		5.01
5.02	00550	ADMINISTRATIVE & GENERAL	0	374,608	76,979	0	7,758,594	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	16,917	9,844	0	1,311,560	6.00
7.00	00700	OPERATION OF PLANT	7,415	83,806	0	0	1,015,380	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	77,107	8.00
9.00	00900	HOUSEKEEPING	135	17,367	11,848	0	813,788	9.00
10.00	01000	DIETARY	0	15,676	3,215	0	364,082	10.00
11.00	01100	CAFETERIA	0	0	13,547	0	859,896	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,283	5,667	0	396,410	14.00
15.00	01500	PHARMACY	0	35,780	5,277	0	544,558	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,844	23,010	0	1,714,884	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	43,516	38,320	276,417	3,096,203	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	219,632	21,379	574,980	4,239,142	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	33,800	86,891	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	302,377	29,171	638,422	3,847,656	54.00
60.00	06000	LABORATORY	0	47,360	17,758	619,736	3,341,014	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	13,368	20,269	133,571	1,538,559	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	4,581	21,958	285,964	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	758	6,416	41,404	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,005	375	32,038	57,034	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	37,379	571,111	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	28,949	583,120	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	155,472	729,443	73.00
76.00	03950	SLEEP LAB	0	14,905	3,560	19,414	276,083	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	0	1,029	13,757	512,381	76.02
76.03	03030	WOUNDCARE	0	0	340	11,786	163,798	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	12,444	14,888	28,000	1,210,461	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	36,923	86,316	175,770	6,160,824	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	10,686	14,062	29,524	1,040,221	88.02
91.00	09100	EMERGENCY	0	21,063	42,209	450,864	4,765,749	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7,029	122,761	12,565	93,379	1,034,778	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,579	1,412,643	502,596	3,381,632	48,438,095	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	12,479	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20,696	53	0	118,554	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	0	18,548	13,630	0	3,170,568	194.00
194.01	07951	FOUNDATION	0	0	2,074	0	175,847	194.01
194.02	07952	CROSSFIT	0	8,239	3,829	0	369,549	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,579	1,460,126	522,182	3,381,632	52,285,092	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/20/2023 11:03 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.02	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	PFS & REGISTRATION						5.01
5.02	00550	ADMINISTRATIVE & GENERAL	7,758,594					5.02
6.00	00600	MAINTENANCE & REPAIRS	228,535	1,540,095				6.00
7.00	00700	OPERATION OF PLANT	176,927	330,467	1,522,774			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,436	5,786	8,460	104,789		8.00
9.00	00900	HOUSEKEEPING	141,800	15,836	21,919	10	993,353	9.00
10.00	01000	DIETARY	63,440	46,437	67,900	4,036	45,187	10.00
11.00	01100	CAFETERIA	149,834	21,171	30,956	0	20,601	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	69,073	31,578	46,173	0	30,728	14.00
15.00	01500	PHARMACY	94,888	11,891	17,387	0	11,571	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	298,813	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	539,504	171,226	250,367	38,703	166,619	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	738,658	147,162	215,181	23,926	143,203	50.00
53.00	05300	ANESTHESIOLOGY	15,140	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	670,443	83,180	121,626	7,323	80,942	54.00
60.00	06000	LABORATORY	582,162	43,844	64,109	0	42,665	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	268,089	53,181	77,761	9,823	51,750	66.00
67.00	06700	OCCUPATIONAL THERAPY	49,828	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,215	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	9,938	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	99,514	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	101,607	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	127,103	0	0	0	0	73.00
76.00	03950	SLEEP LAB	48,107	6,218	9,092	2,364	6,051	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	89,281	0	0	0	0	76.02
76.03	03030	WOUNDCARE	28,541	0	0	0	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	210,919	68,434	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,073,492	261,657	382,594	390	254,617	88.01
88.02	08802	RURAL HEALTH CLINIC III	181,255	0	0	0	0	88.02
91.00	09100	EMERGENCY	830,417	116,543	170,409	16,787	113,407	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	180,307	58,516	21,123	749	14,057	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,088,266	1,473,127	1,505,057	104,111	981,398	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,174	6,030	8,817	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,658	0	0	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	552,462	4,283	6,263	0	4,168	194.00
194.01	07951	FOUNDATION	30,641	1,803	2,637	0	1,755	194.01
194.02	07952	CROSSFIT	64,393	54,852	0	678	6,032	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,758,594	1,540,095	1,522,774	104,789	993,353	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/20/2023 11:03 am

		Cost Center Description	DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	PFS & REGISTRATION						5.01
5.02	00550	ADMINISTRATIVE & GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	591,082					10.00
11.00	01100	CAFETERIA	0	1,082,458				11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	36,347	610,309			14.00
15.00	01500	PHARMACY	0	12,094	1,978	694,367		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	108,589	1,696	0	2,123,982	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	583,699	139,697	10,732	0	325,002	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	80,973	31,566	0	43,334	50.00
53.00	05300	ANESTHESIOLOGY	0	8,602	6,282	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	98,887	21,527	0	72,010	54.00
60.00	06000	LABORATORY	0	93,519	208,378	0	207,959	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	65,386	3,393	0	44,183	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,935	63	0	1,062	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,264	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,358	0	0	5,735	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	113,071	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	122,839	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	694,367	0	73.00
76.00	03950	SLEEP LAB	0	12,223	1,400	0	2,549	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	7,383	18,497	238	0	0	76.02
76.03	03030	WOUNDCARE	0	3,557	294	0	37,386	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	9,971	0	90,278	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	214,590	35,932	0	585,641	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	11,911	0	91,765	88.02
91.00	09100	EMERGENCY	0	155,866	16,585	0	557,176	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	3,045	0	59,902	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	591,082	1,065,384	600,901	694,367	2,123,982	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	75	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	0	0	4,850	0	0	194.00
194.01	07951	FOUNDATION	0	3,816	21	0	0	194.01
194.02	07952	CROSSFIT	0	13,258	4,462	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	591,082	1,082,458	610,309	694,367	2,123,982	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/20/2023 11:03 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	PFS & REGISTRATION						5.01
5.02	00550	ADMINISTRATIVE & GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	5,321,752	-269,395	5,052,357		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,663,145	0	5,663,145		50.00
53.00	05300	ANESTHESIOLOGY	0	116,915	0	116,915		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,003,594	0	5,003,594		54.00
60.00	06000	LABORATORY	0	4,583,650	0	4,583,650		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	269,395	269,395		64.00
66.00	06600	PHYSICAL THERAPY	0	2,112,125	0	2,112,125		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	349,852	0	349,852		67.00
68.00	06800	SPEECH PATHOLOGY	0	50,883	0	50,883		68.00
69.00	06900	ELECTROCARDIOLOGY	0	74,065	0	74,065		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	783,696	0	783,696		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	807,566	0	807,566		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,550,913	0	1,550,913		73.00
76.00	03950	SLEEP LAB	0	364,087	0	364,087		76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0		76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	627,780	0	627,780		76.02
76.03	03030	WOUNDCARE	0	233,576	0	233,576		76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,590,063	0	1,590,063		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	8,969,737	0	8,969,737		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,325,152	0	1,325,152		88.02
91.00	09100	EMERGENCY	0	6,742,939	0	6,742,939		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,372,477	0	1,372,477		95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	47,643,967	0	47,643,967		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29,500	0	29,500		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	139,287	0	139,287		192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	0	3,742,594	0	3,742,594		194.00
194.01	07951	FOUNDATION	0	216,520	0	216,520		194.01
194.02	07952	CROSSFIT	0	513,224	0	513,224		194.02
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	52,285,092	0	52,285,092		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/20/2023 11:03 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	RURAL HEALTH CLINIC I BUILDING	RURAL HEALTH CLINIC III BUILDING	CROSSFIT BUILDING	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,004	0	0	0	4.00
5.01	00540	PFS & REGISTRATION	0	41,402	3,687	1,049	0	5.01
5.02	00550	ADMINISTRATIVE & GENERAL	198,054	296,581	0	0	17,338	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	9,486	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	587,680	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,974	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	31,023	0	0	0	9.00
10.00	01000	DIETARY	1,647	96,100	0	0	0	10.00
11.00	01100	CAFETERIA	0	43,813	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	65,350	0	0	0	14.00
15.00	01500	PHARMACY	0	24,608	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	82,679	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	325	354,350	0	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	94,765	304,551	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	361,671	164,560	8,768	0	0	54.00
60.00	06000	LABORATORY	5,000	90,735	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	110,057	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SLEEP LAB	0	12,868	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	28,905	0	0	0	0	76.02
76.03	03030	WOUNDCARE	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	163,811	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	541,497	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	59,516	0	88.02
91.00	09100	EMERGENCY	0	241,184	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	29,895	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	773,046	3,061,718	176,266	60,565	17,338	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,479	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	80,138	0	0	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	42,963	8,864	0	27,379	0	194.00
194.01	07951	FOUNDATION	0	3,732	0	0	0	194.01
194.02	07952	CROSSFIT	121,906	0	0	0	34,675	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,018,053	3,086,793	176,266	87,944	52,013	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/20/2023 11:03 am

		Cost Center Description	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	PFS & REGISTRATION	
			AMBULANCE/MAINTENANCE GARAGE	MVBLE EQUIP				
			1.04	2.00	2A	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	322	4,326	4,326		4.00
5.01	00540	PFS & REGISTRATION	0	0	46,138	379	46,517	5.01
5.02	00550	ADMINISTRATIVE & GENERAL	0	374,608	886,581	639	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	16,917	26,403	82	0	6.00
7.00	00700	OPERATION OF PLANT	7,415	83,806	678,901	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	11,974	0	0	8.00
9.00	00900	HOUSEKEEPING	135	17,367	48,525	98	0	9.00
10.00	01000	DIETARY	0	15,676	113,423	27	0	10.00
11.00	01100	CAFETERIA	0	0	43,813	112	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,283	70,633	47	0	14.00
15.00	01500	PHARMACY	0	35,780	60,388	44	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,844	97,523	191	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	43,516	398,191	318	3,802	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	219,632	618,948	177	7,908	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	465	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	302,377	837,376	242	8,788	54.00
60.00	06000	LABORATORY	0	47,360	143,095	147	8,524	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	13,368	123,425	168	1,837	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	38	302	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	6	88	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,005	3,005	3	441	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	514	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	398	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,138	73.00
76.00	03950	SLEEP LAB	0	14,905	27,773	30	267	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	0	28,905	9	189	76.02
76.03	03030	WOUNDCARE	0	0	0	3	162	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	12,444	176,255	124	385	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	36,923	578,420	709	2,418	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	10,686	70,202	117	406	88.02
91.00	09100	EMERGENCY	0	21,063	262,247	350	6,201	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7,029	122,761	159,685	104	1,284	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,579	1,412,643	5,516,155	4,164	46,517	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	12,479	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20,696	100,834	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	0	18,548	97,754	113	0	194.00
194.01	07951	FOUNDATION	0	0	3,732	17	0	194.01
194.02	07952	CROSSFIT	0	8,239	164,820	32	0	194.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,579	1,460,126	5,895,774	4,326	46,517	202.00

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		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.02	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	PFS & REGISTRATION						5.01
5.02	00550	ADMINISTRATIVE & GENERAL	887,220					5.02
6.00	00600	MAINTENANCE & REPAIRS	26,134	52,619				6.00
7.00	00700	OPERATION OF PLANT	20,232	11,291	710,424			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,536	198	3,947	17,655		8.00
9.00	00900	HOUSEKEEPING	16,216	541	10,226	2	75,608	9.00
10.00	01000	DIETARY	7,255	1,587	31,677	680	3,439	10.00
11.00	01100	CAFETERIA	17,134	723	14,442	0	1,568	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,899	1,079	21,541	0	2,339	14.00
15.00	01500	PHARMACY	10,851	406	8,112	0	881	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	34,171	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	61,695	5,850	116,804	6,521	12,682	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	84,469	5,028	100,389	4,031	10,900	50.00
53.00	05300	ANESTHESIOLOGY	1,731	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	76,668	2,842	56,743	1,234	6,161	54.00
60.00	06000	LABORATORY	66,573	1,498	29,909	0	3,247	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	30,657	1,817	36,278	1,655	3,939	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,698	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	825	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,136	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,380	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,619	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,535	0	0	0	0	73.00
76.00	03950	SLEEP LAB	5,501	212	4,242	398	461	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	10,210	0	0	0	0	76.02
76.03	03030	WOUNDCARE	3,264	0	0	0	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	24,120	2,338	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	122,747	8,940	178,494	66	19,379	88.01
88.02	08802	RURAL HEALTH CLINIC III	20,727	0	0	0	0	88.02
91.00	09100	EMERGENCY	94,962	3,982	79,501	2,828	8,632	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	20,619	1,999	9,854	126	1,070	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	810,564	50,331	702,159	17,541	74,698	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	249	206	4,113	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,362	0	0	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	63,177	146	2,922	0	317	194.00
194.01	07951	FOUNDATION	3,504	62	1,230	0	134	194.01
194.02	07952	CROSSFIT	7,364	1,874	0	114	459	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	887,220	52,619	710,424	17,655	75,608	202.00

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		Cost Center Description	DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	PFS & REGISTRATION						5.01
5.02	00550	ADMINISTRATIVE & GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	158,088					10.00
11.00	01100	CAFETERIA	0	77,792				11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,612	106,150			14.00
15.00	01500	PHARMACY	0	869	344	81,895		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,804	295	0	139,984	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	156,113	10,039	1,867	0	21,420	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,819	5,490	0	2,856	50.00
53.00	05300	ANESTHESIOLOGY	0	618	1,093	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,107	3,744	0	4,746	54.00
60.00	06000	LABORATORY	0	6,721	36,239	0	13,706	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	4,699	590	0	2,912	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	930	11	0	70	67.00
68.00	06800	SPEECH PATHOLOGY	0	163	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	98	0	0	378	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	19,667	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	21,366	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	81,895	0	73.00
76.00	03950	SLEEP LAB	0	878	244	0	168	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	1,975	1,329	41	0	0	76.02
76.03	03030	WOUNDCARE	0	256	51	0	2,464	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,734	0	5,950	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	15,422	6,250	0	38,597	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	2,072	0	6,048	88.02
91.00	09100	EMERGENCY	0	11,201	2,885	0	36,721	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	530	0	3,948	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	158,088	76,565	104,513	81,895	139,984	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	13	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	0	0	844	0	0	194.00
194.01	07951	FOUNDATION	0	274	4	0	0	194.01
194.02	07952	CROSSFIT	0	953	776	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	158,088	77,792	106,150	81,895	139,984	202.00

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		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	PFS & REGISTRATION						5.01
5.02	00550	ADMINISTRATIVE & GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		795,302	0	795,302		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		846,015	0	846,015		50.00
53.00	05300	ANESTHESIOLOGY		3,907	0	3,907		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		1,005,651	0	1,005,651		54.00
60.00	06000	LABORATORY		309,659	0	309,659		60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0		64.00
66.00	06600	PHYSICAL THERAPY		207,977	0	207,977		66.00
67.00	06700	OCCUPATIONAL THERAPY		7,049	0	7,049		67.00
68.00	06800	SPEECH PATHOLOGY		1,082	0	1,082		68.00
69.00	06900	ELECTROCARDIOLOGY		5,061	0	5,061		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		31,561	0	31,561		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		33,383	0	33,383		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		98,568	0	98,568		73.00
76.00	03950	SLEEP LAB		40,174	0	40,174		76.00
76.01	03951	DIABETIC EDUCATION		0	0	0		76.01
76.02	03020	SENIOR LIFE SOLUTIONS		42,658	0	42,658		76.02
76.03	03030	WOUNDCARE		6,200	0	6,200		76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		210,906	0	210,906		88.00
88.01	08801	RURAL HEALTH CLINIC II		971,442	0	971,442		88.01
88.02	08802	RURAL HEALTH CLINIC III		99,572	0	99,572		88.02
91.00	09100	EMERGENCY		509,510	0	509,510		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		199,219	0	199,219		95.00
102.00	10200	OPIOID TREATMENT PROGRAM		0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,424,896	0	5,424,896		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		17,047	0	17,047		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		103,209	0	103,209		192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO		165,273	0	165,273		194.00
194.01	07951	FOUNDATION		8,957	0	8,957		194.01
194.02	07952	CROSSFIT		176,392	0	176,392		194.02
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	5,895,774	0	5,895,774		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/20/2023 11:03 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	RURAL HEALTH CLINIC I BUILDING (SQUARE FEET)	RURAL HEALTH CLINIC III BUILDING (SQUARE FEET)	CROSSFIT BUILDING (SQUARE FEET)	AMBULANCE/MAINTENANCE GARAGE (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	79,402					1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING	0	3,920				1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING	0	0	6,877			1.02
1.03	00103	CROSSFIT BUILDING	0	0	0	4,380		1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE	0	0	0	0	4,866	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	103	0	0	0	0	4.00
5.01	00540	PFS & REGISTRATION	1,065	82	82	0	0	5.01
5.02	00550	ADMINISTRATIVE & GENERAL	7,629	0	0	1,460	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	244	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	15,117	0	0	0	2,475	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	308	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	798	0	0	0	45	9.00
10.00	01000	DIETARY	2,472	0	0	0	0	10.00
11.00	01100	CAFETERIA	1,127	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,681	0	0	0	0	14.00
15.00	01500	PHARMACY	633	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,115	0	0	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,834	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,233	195	0	0	0	54.00
60.00	06000	LABORATORY	2,334	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	2,831	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SLEEP LAB	331	0	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	0	0	0	0	76.02
76.03	03030	WOUNDCARE	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,643	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	13,929	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	4,654	0	0	88.02
91.00	09100	EMERGENCY	6,204	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	769	0	0	0	2,346	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	78,757	3,920	4,736	1,460	4,866	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	321	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	228	0	2,141	0	0	194.00
194.01	07951	FOUNDATION	96	0	0	0	0	194.01
194.02	07952	CROSSFIT	0	0	0	2,920	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,086,793	176,266	87,944	52,013	14,579	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	38.875507	44.965816	12.788134	11.875114	2.996095	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						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: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/20/2023 11:03 am

		Cost Center Description	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PFS & REGISTRATION (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			2.00	4.00	5.01	5A.02	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,411,860					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	311	20,931,128				4.00
5.01	00540	PFS & REGISTRATION	0	1,828,954	126,731,639			5.01
5.02	00550	ADMINISTRATIVE & GENERAL	362,224	3,085,584	0	-7,758,594	44,526,498	5.02
6.00	00600	MAINTENANCE & REPAIRS	16,358	394,587	0	0	1,311,560	6.00
7.00	00700	OPERATION OF PLANT	81,036	0	0	0	1,015,380	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	77,107	8.00
9.00	00900	HOUSEKEEPING	16,793	474,903	0	0	813,788	9.00
10.00	01000	DIETARY	15,158	128,861	0	0	364,082	10.00
11.00	01100	CAFETERIA	0	543,017	0	0	859,896	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,108	227,152	0	0	396,410	14.00
15.00	01500	PHARMACY	34,597	211,500	0	0	544,558	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,353	922,328	0	0	1,714,884	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,078	1,535,996	10,359,296	0	3,096,203	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	212,372	856,926	21,548,554	0	4,239,142	50.00
53.00	05300	ANESTHESIOLOGY	0	0	1,266,708	0	86,891	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	292,382	1,169,272	23,924,244	0	3,847,656	54.00
60.00	06000	LABORATORY	45,794	711,816	23,225,872	0	3,341,014	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	12,926	812,467	5,005,835	0	1,538,559	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	183,632	822,911	0	285,964	67.00
68.00	06800	SPEECH PATHOLOGY	0	30,374	240,453	0	41,404	68.00
69.00	06900	ELECTROCARDIOLOGY	2,906	15,028	1,200,682	0	57,034	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,400,846	0	571,111	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,084,926	0	583,120	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,826,625	0	729,443	73.00
76.00	03950	SLEEP LAB	14,412	142,711	727,593	0	276,083	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	41,250	515,569	0	512,381	76.02
76.03	03030	WOUNDCARE	0	13,630	441,721	0	163,798	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	12,033	596,753	1,049,352	0	1,210,461	88.00
88.01	08801	RURAL HEALTH CLINIC II	35,702	3,460,150	6,587,332	0	6,160,824	88.01
88.02	08802	RURAL HEALTH CLINIC III	10,333	563,660	1,106,474	0	1,040,221	88.02
91.00	09100	EMERGENCY	20,367	1,691,890	16,897,069	0	4,765,749	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	118,703	503,631	3,499,577	0	1,034,778	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,365,946	20,146,072	126,731,639	-7,758,594	40,679,501	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	12,479	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,012	2,133	0	0	118,554	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	17,935	546,317	0	0	3,170,568	194.00
194.01	07951	FOUNDATION	0	83,142	0	0	175,847	194.01
194.02	07952	CROSSFIT	7,967	153,464	0	0	369,549	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,460,126	522,182	3,381,632		7,758,594	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.034186	0.024948	0.026683		0.174247	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		4,326	46,517		887,220	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000207	0.000367		0.019926	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/20/2023 11:03 am

		Cost Center Description	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PFS & REGISTRATION (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			2.00	4.00	5.01	5A.02	5.02	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/20/2023 11:03 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	PFS & REGISTRATION						5.01
5.02	00550	ADMINISTRATIVE & GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS	81,985					6.00
7.00	00700	OPERATION OF PLANT	17,592	55,439				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	308	308	97,415			8.00
9.00	00900	HOUSEKEEPING	843	798	9	54,342		9.00
10.00	01000	DIETARY	2,472	2,472	3,752	2,472	17,292	10.00
11.00	01100	CAFETERIA	1,127	1,127	0	1,127	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,681	1,681	0	1,681	0	14.00
15.00	01500	PHARMACY	633	633	0	633	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,115	9,115	35,979	9,115	17,076	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,834	7,834	22,242	7,834	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,428	4,428	6,808	4,428	0	54.00
60.00	06000	LABORATORY	2,334	2,334	0	2,334	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	2,831	2,831	9,132	2,831	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SLEEP LAB	331	331	2,198	331	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	0	0	0	216	76.02
76.03	03030	WOUNDCARE	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,643	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	13,929	13,929	363	13,929	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	6,204	6,204	15,606	6,204	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,115	769	696	769	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	78,420	54,794	96,785	53,688	17,292	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	321	321	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	228	228	0	228	0	194.00
194.01	07951	FOUNDATION	96	96	0	96	0	194.01
194.02	07952	CROSSFIT	2,920	0	630	330	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,540,095	1,522,774	104,789	993,353	591,082	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.785083	27.467559	1.075697	18.279655	34.182396	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	52,619	710,424	17,655	75,608	158,088	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.641813	12.814517	0.181235	1.391336	9.142262	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: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/20/2023 11:03 am

		Cost Center Description	CAFETERIA (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	14.00	15.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC I BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
1.04	00104	AMBULANCE/MAINTENANCE GARAGE						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	PFS & REGISTRATION						5.01
5.02	00550	ADMINISTRATIVE & GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	16,737					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	562	2,753,316				14.00
15.00	01500	PHARMACY	187	8,923	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,679	7,652	0	9,999		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,160	48,416	0	1,530	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,252	142,407	0	204	0	50.00
53.00	05300	ANESTHESIOLOGY	133	28,340	0	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,529	97,114	0	339	0	54.00
60.00	06000	LABORATORY	1,446	940,065	0	979	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,011	15,307	0	208	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	200	285	0	5	0	67.00
68.00	06800	SPEECH PATHOLOGY	35	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	21	0	0	27	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	510,103	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	554,171	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0	0	73.00
76.00	03950	SLEEP LAB	189	6,317	0	12	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	286	1,072	0	0	0	76.02
76.03	03030	WOUNDCARE	55	1,328	0	176	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	44,983	0	425	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,318	162,100	0	2,757	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	53,734	0	432	0	88.02
91.00	09100	EMERGENCY	2,410	74,820	0	2,623	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	13,738	0	282	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,473	2,710,875	100	9,999	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	337	0	0	0	192.00
194.00	07950	RETAIL PHARMACIES - KIRBY & CERRO	0	21,882	0	0	0	194.00
194.01	07951	FOUNDATION	59	93	0	0	0	194.01
194.02	07952	CROSSFIT	205	20,129	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,082,458	610,309	694,367	2,123,982	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	64.674553	0.221663	6,943.670000	212.419442	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	77,792	106,150	81,895	139,984	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.647906	0.038554	818.950000	13.999800	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: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-2 | Date/Time Prepared: 11/20/2023 11:03 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
7.00		ADULTS & PEDIATRICS	1	30.00	-269,395	7.00
8.00		IV THERAPY	1	64.00	269,395	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/20/2023 11:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,052,357		5,052,357	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,663,145		5,663,145	0	0	50.00
53.00	05300	ANESTHESIOLOGY	116,915		116,915	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,003,594		5,003,594	0	0	54.00
60.00	06000	LABORATORY	4,583,650		4,583,650	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	269,395		269,395	0	0	64.00
66.00	06600	PHYSICAL THERAPY	2,112,125	0	2,112,125	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	349,852	0	349,852	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	50,883	0	50,883	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	74,065		74,065	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	783,696		783,696	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	807,566		807,566	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,550,913		1,550,913	0	0	73.00
76.00	03950	SLEEP LAB	364,087		364,087	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0		0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	627,780		627,780	0	0	76.02
76.03	03030	WOUNDCARE	233,576		233,576	0	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,590,063		1,590,063	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	8,969,737		8,969,737	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,325,152		1,325,152	0	0	88.02
91.00	09100	EMERGENCY	6,742,939		6,742,939	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	958,316		958,316		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,372,477		1,372,477	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	48,602,283	0	48,602,283	0	0	200.00
201.00		Less Observation Beds	958,316		958,316		0	201.00
202.00		Total (see instructions)	47,643,967	0	47,643,967	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I | Date/Time Prepared: 11/20/2023 11:03 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	8,266,771		8,266,771			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	103,356	21,445,198	21,548,554	0.262809	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	5,660	1,261,048	1,266,708	0.092298	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	383,752	23,540,492	23,924,244	0.209143	0.000000	54.00
60.00	06000	LABORATORY	768,029	22,457,843	23,225,872	0.197351	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	7,507	960,302	967,809	0.278356	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	407,415	4,598,420	5,005,835	0.421933	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	341,944	480,967	822,911	0.425140	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	37,938	202,515	240,453	0.211613	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	23,760	1,176,922	1,200,682	0.061686	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	145,980	1,254,866	1,400,846	0.559445	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,084,926	1,084,926	0.744351	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,086,455	4,740,170	5,826,625	0.266177	0.000000	73.00
76.00	03950	SLEEP LAB	0	727,593	727,593	0.500399	0.000000	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0.000000	0.000000	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	515,569	515,569	1.217645	0.000000	76.02
76.03	03030	WOUNDCARE	0	441,721	441,721	0.528786	0.000000	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,049,352	1,049,352			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	6,587,332	6,587,332			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,106,474	1,106,474			88.02
91.00	09100	EMERGENCY	3,859	16,893,210	16,897,069	0.399060	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	9,443	1,115,273	1,124,716	0.852052	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,499,577	3,499,577	0.392184	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	11,591,869	115,139,770	126,731,639			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,591,869	115,139,770	126,731,639			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/20/2023 11:03 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
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03950	SLEEP LAB	0.000000	76.00
76.01	03951	DIABETIC EDUCATION	0.000000	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0.000000	76.02
76.03	03030	WOUNDCARE	0.000000	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
88.02	08802	RURAL HEALTH CLINIC III		88.02
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 11/20/2023 11:03 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	846,015	21,548,554	0.039261	37,011	1,453	50.00
53.00	05300	ANESTHESIOLOGY	3,907	1,266,708	0.003084	2,264	7	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,005,651	23,924,244	0.042035	103,056	4,332	54.00
60.00	06000	LABORATORY	309,659	23,225,872	0.013333	155,242	2,070	60.00
64.00	06400	INTRAVENOUS THERAPY	0	967,809	0.000000	1,566	0	64.00
66.00	06600	PHYSICAL THERAPY	207,977	5,005,835	0.041547	17,541	729	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,049	822,911	0.008566	16,374	140	67.00
68.00	06800	SPEECH PATHOLOGY	1,082	240,453	0.004500	6,367	29	68.00
69.00	06900	ELECTROCARDIOLOGY	5,061	1,200,682	0.004215	11,232	47	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,561	1,400,846	0.022530	32,414	730	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,383	1,084,926	0.030770	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	98,568	5,826,625	0.016917	165,022	2,792	73.00
76.00	03950	SLEEP LAB	40,174	727,593	0.055215	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0.000000	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	42,658	515,569	0.082740	0	0	76.02
76.03	03030	WOUNDCARE	6,200	441,721	0.014036	0	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	210,906	1,049,352	0.200987	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	971,442	6,587,332	0.147471	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	99,572	1,106,474	0.089990	0	0	88.02
91.00	09100	EMERGENCY	509,510	16,897,069	0.030154	3,859	116	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	150,850	1,124,716	0.134123	5,208	699	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	4,581,225	114,965,291		557,156	13,144	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/20/2023 11:03 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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SLEEP LAB	0	0	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	0	0	0	0	76.02
76.03	03030	WOUNDCARE	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		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: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/20/2023 11:03 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	21,548,554	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,266,708	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,924,244	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	23,225,872	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	967,809	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,005,835	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	822,911	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	240,453	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,200,682	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,400,846	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,084,926	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,826,625	0.000000	73.00
76.00	03950	SLEEP LAB	0	0	0	727,593	0.000000	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0.000000	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0	0	0	515,569	0.000000	76.02
76.03	03030	WOUNDCARE	0	0	0	441,721	0.000000	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,049,352	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	6,587,332	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,106,474	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	16,897,069	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,124,716	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	114,965,291		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/20/2023 11:03 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	37,011	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,264	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	103,056	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	155,242	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	1,566	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	17,541	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	16,374	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	6,367	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	11,232	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	32,414	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	165,022	0	0	0	73.00
76.00	03950	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.000000	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	0.000000	0	0	0	0	76.02
76.03	03030	WOUNDCARE	0.000000	0	0	0	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
91.00	09100	EMERGENCY	0.000000	3,859	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	5,208	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		557,156	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/20/2023 11:03 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	0.262809	0	3,513,191	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.092298	0	229,796	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209143	0	4,840,089	0	0	54.00
60.00	06000	LABORATORY	0.197351	0	4,558,946	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.278356	0	334,084	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.421933	0	886,962	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.425140	0	108,065	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.211613	0	67,584	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061686	0	275,344	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.559445	0	263,354	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.744351	0	219,870	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.266177	0	2,027,325	0	0	73.00
76.00	03950	SLEEP LAB	0.500399	0	178,170	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.000000	0	0	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	1.217645	0	382,375	0	0	76.02
76.03	03030	WOUNDCARE	0.528786	0	210,504	0	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
91.00	09100	EMERGENCY	0.399060	0	3,251,450	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.852052	0	375,757	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.392184		0			95.00
200.00		Subtotal (see instructions)		0	21,722,866	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	21,722,866	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/20/2023 11:03 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	923,298	0	50.00
53.00	05300	ANESTHESIOLOGY	21,210	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,012,271	0	54.00
60.00	06000	LABORATORY	899,713	0	60.00
64.00	06400	INTRAVENOUS THERAPY	92,994	0	64.00
66.00	06600	PHYSICAL THERAPY	374,239	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	45,943	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,302	0	68.00
69.00	06900	ELECTROCARDIOLOGY	16,985	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	147,332	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	163,660	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	539,627	0	73.00
76.00	03950	SLEEP LAB	89,156	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	465,597	0	76.02
76.03	03030	WOUNDCARE	111,312	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
91.00	09100	EMERGENCY	1,297,524	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	320,165	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	6,535,328	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	6,535,328	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/20/2023 11:03 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)	2,185	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	976	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)	593	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	517	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)	512	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	97	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)	83	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	199	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)	261	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	275	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	188.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	208.70	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,052,357	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)	18,279	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)	17,322	25.00
26.00	Total swing-bed cost (see instructions)	2,610,282	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,442,075	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)	2,442,075	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)	2,502.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	497,922	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)	497,922	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/20/2023 11:03 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)	147,000	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)	644,922	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)	653,053	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	688,083	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	1,341,136	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)	383	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,502.13	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	958,316	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/20/2023 11:03 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	795,302	5,052,357	0.157412	958,316	150,850	90.00
91.00	Nursing Program cost	0	5,052,357	0.000000	958,316	0	91.00
92.00	Allied health cost	0	5,052,357	0.000000	958,316	0	92.00
93.00	All other Medical Education	0	5,052,357	0.000000	958,316	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/20/2023 11:03 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		1,007,203		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.262809	37,011	9,727	50.00
53.00	05300	ANESTHESIOLOGY	0.092298	2,264	209	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209143	103,056	21,553	54.00
60.00	06000	LABORATORY	0.197351	155,242	30,637	60.00
64.00	06400	INTRAVENOUS THERAPY	0.278356	1,566	436	64.00
66.00	06600	PHYSICAL THERAPY	0.421933	17,541	7,401	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.425140	16,374	6,961	67.00
68.00	06800	SPEECH PATHOLOGY	0.211613	6,367	1,347	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061686	11,232	693	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.559445	32,414	18,134	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.744351	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.266177	165,022	43,925	73.00
76.00	03950	SLEEP LAB	0.500399	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.000000	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	1.217645	0	0	76.02
76.03	03030	WOUNDCARE	0.528786	0	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	09100	EMERGENCY	0.399060	3,859	1,540	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.852052	5,208	4,437	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		557,156	147,000	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)		557,156		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1301 | Component CCN: 14-Z301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/20/2023 11:03 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	0.262809	6,802	1,788	50.00
53.00	05300	ANESTHESIOLOGY	0.092298	1,132	104	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209143	45,315	9,477	54.00
60.00	06000	LABORATORY	0.197351	154,498	30,490	60.00
64.00	06400	INTRAVENOUS THERAPY	0.278356	1,323	368	64.00
66.00	06600	PHYSICAL THERAPY	0.421933	169,654	71,583	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.425140	145,875	62,017	67.00
68.00	06800	SPEECH PATHOLOGY	0.211613	17,288	3,658	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061686	864	53	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.559445	24,422	13,663	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.744351	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.266177	200,953	53,489	73.00
76.00	03950	SLEEP LAB	0.500399	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.000000	0	0	76.01
76.02	03020	SENIOR LIFE SOLUTIONS	1.217645	0	0	76.02
76.03	03030	WOUNDCARE	0.528786	0	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	09100	EMERGENCY	0.399060	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.852052	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		768,126	246,690	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)		768,126		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/20/2023 11:03 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,535,328	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)	6,535,328	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)	6,600,681	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)	33,698	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,247,237	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)	3,319,746	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)	3,319,746	30.00
31.00	Primary payer payments	837	31.00
32.00	Subtotal (line 30 minus line 31)	3,318,909	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)	285,731	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	185,725	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	222,387	36.00
37.00	Subtotal (see instructions)	3,504,634	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,504,634	40.00
40.01	Sequestration adjustment (see instructions)	70,093	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,808,931	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)	-374,390	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: 14-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/20/2023 11:03 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: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/20/2023 11:03 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		606,726		3,808,931	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	03/03/2023	65,000		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-65,000		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)		541,726		3,808,931	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		34,014		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		374,390	6.02
7.00	Total Medicare program liability (see instructions)		575,740		3,434,541	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1301 | Component CCN: 14-Z301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/20/2023 11:03 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,560,423		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	03/03/2023	37,400		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-37,400		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,523,023		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		42,531		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,565,554		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet E-1 Part II Date/Time Prepared: 11/20/2023 11:03 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: 14-1301 | Component CCN: 14-Z301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-2 | Date/Time Prepared: 11/20/2023 11:03 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,354,547	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)	249,157	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	536	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,603,704	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,603,704	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,603,704	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,200	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,597,504	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,597,504	0	19.00
19.01	Sequestration adjustment (see instructions)	31,950	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	1,523,023	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)	42,531	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: 14-1301	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part V Date/Time Prepared: 11/20/2023 11:03 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	644,922	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)	644,922	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	651,371	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)	651,371	19.00
20.00	Deductibles (exclude professional component)	66,144	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	585,227	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	585,227	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	3,481	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	2,263	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,997	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	587,490	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)	587,490	30.00
30.01	Sequestration adjustment (see instructions)	11,750	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	541,726	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)	34,014	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: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G | Date/Time Prepared: 11/20/2023 11:03 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	10,947,180	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	6,504,408	0	0	0	4.00
5.00	Other receivable	1,008,183	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,163,770	0	0	0	7.00
8.00	Prepaid expenses	2,252,778	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)	21,876,319	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	517,274	0	0	0	12.00
13.00	Land improvements	9,154,990	0	0	0	13.00
14.00	Accumulated depreciation	-4,186,721	0	0	0	14.00
15.00	Buildings	39,567,752	0	0	0	15.00
16.00	Accumulated depreciation	-12,841,257	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	36,094,475	0	0	0	19.00
20.00	Accumulated depreciation	-21,867,389	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	436,031	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	46,875,155	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	12,489,250	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	60,461,934	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	72,951,184	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	141,702,658	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,212,127	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,216,483	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,007,780	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	2,043,041	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,479,431	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	35,031,548	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	328,495	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	35,360,043	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	44,839,474	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	96,863,184				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)	96,863,184	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	141,702,658	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-1 | Date/Time Prepared: 11/20/2023 11:03 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		80,882,344		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		10,606,653				2.00
3.00	Total (sum of line 1 and line 2)		91,488,997		0		3.00
4.00	INCREASE IN NET ASSETS AUXILIARY	14,057		0		0	4.00
5.00	RESTRICTED NET ASSETS	16,249		0		0	5.00
6.00	INTERCOMPANY TRANSACTIONS	8,845		0		0	6.00
7.00	CHANGE IN INTEREST PERPETUAL TRUST	5,335,035		0		0	7.00
8.00	ROUNDING	1		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		5,374,187		0		10.00
11.00	Subtotal (line 3 plus line 10)		96,863,184		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		96,863,184		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	INCREASE IN NET ASSETS AUXILIARY		0			4.00
5.00	RESTRICTED NET ASSETS		0			5.00
6.00	INTERCOMPANY TRANSACTIONS		0			6.00
7.00	CHANGE IN INTEREST PERPETUAL TRUST		0			7.00
8.00	ROUNDING		0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/20/2023 11:03 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,692,617		3,692,617	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	3,991,507		3,991,507	5.00
6.00	Swing bed - NF	582,647		582,647	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)	8,266,771		8,266,771	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)	8,266,771		8,266,771	17.00
18.00	Ancillary services	3,311,796	84,888,552	88,200,348	18.00
19.00	Outpatient services	13,302	18,008,483	18,021,785	19.00
20.00	RURAL HEALTH CLINIC	0	1,049,352	1,049,352	20.00
20.01	RURAL HEALTH CLINIC II	0	6,587,332	6,587,332	20.01
20.02	RURAL HEALTH CLINIC III	0	1,106,474	1,106,474	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	3,499,577	3,499,577	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	540,299	10,009,472	10,549,771	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,132,168	125,149,242	137,281,410	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		59,664,349		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)		59,664,349		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-3 | Date/Time Prepared: 11/20/2023 11:03 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	137,281,410	1.00
2.00	Less contractual allowances and discounts on patients' accounts	76,411,431	2.00
3.00	Net patient revenues (line 1 minus line 2)	60,869,979	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	59,664,349	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,205,630	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	1,608,968	6.00
7.00	Income from investments	2,432,805	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	198,877	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	58	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	68,523	22.00
23.00	Governmental appropriations	0	23.00
24.00	340B PHARMACY	717,273	24.00
24.01	GRANT INCOME	108,997	24.01
24.02	FOUNDATION INCOME	279,075	24.02
24.03	RETAIL PHARMACY INCOME	2,911,605	24.03
24.04	TIF INCOME	870,923	24.04
24.05	AMBULANCE INCOME	63,278	24.05
24.06	MISCELLANEOUS INCOME	211,044	24.06
24.07	MISCELLANEOUS DIETARY INCOME	793	24.07
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	9,472,219	25.00
26.00	Total (line 5 plus line 25)	10,677,849	26.00
27.00	TIF INCOME	62,441	27.00
27.01	INTERCOMPANY	8,755	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	71,196	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	10,606,653	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301 | Component CCN: 14-3438 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/20/2023 11:03 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	171,851	0	171,851	0	171,851	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	179,137	0	179,137	-266	178,871	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	165,510	0	165,510	0	165,510	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	80,254	0	80,254	0	80,254	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)	596,752	0	596,752	-266	596,486	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	35,091	35,091	0	35,091	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	35,091	35,091	0	35,091	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	596,752	35,091	631,843	-266	631,577	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	266	266	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	266	266	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	38,117	38,117	0	38,117	29.00
30.00	Administrative Costs	75,399	334,866	410,265	-88,781	321,484	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	75,399	372,983	448,382	-88,781	359,601	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	672,151	408,074	1,080,225	-88,781	991,444	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301 | Component CCN: 14-3438 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/20/2023 11:03 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	171,851		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	178,871		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	165,510		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	80,254		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	596,486		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	35,091		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	35,091		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	631,577		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	266		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	266		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	38,117		29.00
30.00	Administrative Costs	-126	321,358		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-126	359,475		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-126	991,318		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301 | Component CCN: 14-3495 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/20/2023 11:03 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	981,296	0	981,296	-5,231	976,065	1.00
2.00	Physician Assistant	147,602	0	147,602	-142	147,460	2.00
3.00	Nurse Practitioner	791,242	0	791,242	-6,106	785,136	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,157,656	0	1,157,656	0	1,157,656	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	165,453	43,561	209,014	0	209,014	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	3,243,249	43,561	3,286,810	-11,479	3,275,331	10.00
11.00	Physician Services Under Agreement	0	712,436	712,436	-119	712,317	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	712,436	712,436	-119	712,317	14.00
15.00	Medical Supplies	0	109,717	109,717	0	109,717	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	109,717	109,717	0	109,717	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,243,249	865,714	4,108,963	-11,598	4,097,365	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	11,598	11,598	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	11,598	11,598	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	4,540	4,540	0	4,540	29.00
30.00	Administrative Costs	664,752	1,484,084	2,148,836	-484,507	1,664,329	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	664,752	1,488,624	2,153,376	-484,507	1,668,869	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,908,001	2,354,338	6,262,339	-484,507	5,777,832	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301 | Component CCN: 14-3495 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/20/2023 11:03 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	976,065		1.00
2.00	Physician Assistant	0	147,460		2.00
3.00	Nurse Practitioner	0	785,136		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	1,157,656		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	209,014		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,275,331		10.00
11.00	Physician Services Under Agreement	-456,895	255,422		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)	-456,895	255,422		14.00
15.00	Medical Supplies	0	109,717		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	109,717		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-456,895	3,640,470		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	11,598		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	11,598		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	4,540		29.00
30.00	Administrative Costs	-619	1,663,710		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-619	1,668,250		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-457,514	5,320,318		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301 | Component CCN: 14-8566 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/20/2023 11:03 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	176,184	0	176,184	0	176,184	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	199,322	0	199,322	-278	199,044	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	174,350	0	174,350	0	174,350	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	13,804	0	13,804	0	13,804	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)	563,660	0	563,660	-278	563,382	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	38,988	38,988	0	38,988	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	38,988	38,988	0	38,988	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	563,660	38,988	602,648	-278	602,370	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	278	278	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	278	278	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	34,052	34,052	0	34,052	29.00
30.00	Administrative Costs	124,957	321,347	446,304	-156,571	289,733	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	124,957	355,399	480,356	-156,571	323,785	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	688,617	394,387	1,083,004	-156,571	926,433	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1301 | Component CCN: 14-8566 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/20/2023 11:03 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	176,184		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	199,044		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	174,350		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	13,804		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	563,382		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	38,988		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	38,988		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	602,370		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	278		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	278		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	34,052		29.00
30.00	Administrative Costs	0	289,733		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	323,785		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	926,433		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1301 | Component CCN: 14-3438 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-2 | Date/Time Prepared: 11/20/2023 11:03 am

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC I Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.39	990	1	0		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.20	2,686	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.59	3,676		1	3,676	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	0.86	353			353	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.45	4,029			4,029	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)					631,577	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					266	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					631,843	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999579	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					359,475	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					598,745	15.00
16.00	Total overhead (sum of lines 14 and 15)					958,220	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					958,220	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					957,817	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,589,394	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1301 | Component CCN: 14-3495 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-2 | Date/Time Prepared: 11/20/2023 11:03 am

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC II Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.79	6,344	1	2		1.00
2.00	Physician Assistant	0.67	2,074	1	1		2.00
3.00	Nurse Practitioner	5.14	11,186	1	5		3.00
4.00	Subtotal (sum of lines 1 through 3)	7.60	19,604		8	19,604	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	1.88	2,019			2,019	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)	9.48	21,623			21,623	8.00
9.00	Physician Services Under Agreements		928			928	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					3,640,470	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					11,598	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,652,068	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.996824	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,668,250	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,649,419	15.00
16.00	Total overhead (sum of lines 14 and 15)					5,317,669	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					5,317,669	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					5,300,780	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					8,941,250	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1301 | Component CCN: 14-8566 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-2 | Date/Time Prepared: 11/20/2023 11:03 am

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC III Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.40	1,013	1	0		1.00
2.00	Physician Assistant	0.00	1	1	0		2.00
3.00	Nurse Practitioner	1.22	2,863	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.62	3,877		1	3,877	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	0.12	419			419	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)	1.74	4,296			4,296	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)					602,370	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					278	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					602,648	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999539	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					323,785	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					398,719	15.00
16.00	Total overhead (sum of lines 14 and 15)					722,504	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					722,504	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					722,171	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,324,541	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1301 Component CCN: 14-3438	Period: From 07/01/2022 To 06/30/2023	Worksheet M-3 Date/Time Prepared: 11/20/2023 11:03 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)			1,589,394	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			43,279	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,546,115	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,029	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			4,029	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			383.75	7.00
		Calculation of Limit (1)			
		Rate Period 1 (07/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 06/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	323.33	335.62		8.00
9.00	Rate for Program covered visits (see instructions)	323.33	335.62		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	231	258		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	74,689	86,590		11.00
12.00	Program covered visits for mental health services (from contractor records)	80	57		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	25,866	19,130		13.00
14.00	Limit adjustment for mental health services (see instructions)	25,866	19,130		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	206,275		16.00
16.01	Total program charges (see instructions)(from contractor's records)		159,855		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		18,525		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		23,904		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.)		136,792		16.04
16.05	Total program cost (see instructions)	0	160,696		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		11,381		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		25,954		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		160,696		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		7,902		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		168,598		22.00
23.00	Allowable bad debts (see instructions)		8,528		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		5,543		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		7,925		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)		174,141		26.00
26.01	Sequestration adjustment (see instructions)		3,483		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		101,841		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)		68,817		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: 14-1301 Component CCN: 14-3495	Period: From 07/01/2022 To 06/30/2023	Worksheet M-3 Date/Time Prepared: 11/20/2023 11:03 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)			8,941,250	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			138,005	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			8,803,245	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			21,623	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			928	5.00
6.00	Total adjusted visits (line 4 plus line 5)			22,551	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			390.37	7.00
		Calculation of Limit (1)			
		Rate Period 1 (07/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 06/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	384.23	398.83		8.00
9.00	Rate for Program covered visits (see instructions)	384.23	390.37		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	1,166	1,178		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	448,012	459,856		11.00
12.00	Program covered visits for mental health services (from contractor records)	80	71		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	30,738	27,716		13.00
14.00	Limit adjustment for mental health services (see instructions)	30,738	27,716		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	966,322		16.00
16.01	Total program charges (see instructions)(from contractor's records)		617,819		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		59,077		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		92,402		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.)		657,623		16.04
16.05	Total program cost (see instructions)	0	750,025		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		51,891		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		101,370		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		750,025		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		27,304		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		777,329		22.00
23.00	Allowable bad debts (see instructions)		18,369		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		11,940		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		15,165		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)		789,269		26.00
26.01	Sequestration adjustment (see instructions)		15,785		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		745,940		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		27,544		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: 14-1301 Component CCN: 14-8566	Period: From 07/01/2022 To 06/30/2023	Worksheet M-3 Date/Time Prepared: 11/20/2023 11:03 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)		1,324,541	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		37,323	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,287,218	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,296	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		4,296	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		299.63	7.00

		Calculation of Limit (1)		
		Rate Period 1 (07/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 06/30/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	338.88	351.76	8.00
9.00	Rate for Program covered visits (see instructions)	299.63	299.63	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	403	394	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	120,751	118,054	11.00
12.00	Program covered visits for mental health services (from contractor records)	23	58	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	6,891	17,379	13.00
14.00	Limit adjustment for mental health services (see instructions)	6,891	17,379	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	263,075	16.00
16.01	Total program charges (see instructions)(from contractor's records)		218,802	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		32,816	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		39,456	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.)		163,698	16.04
16.05	Total program cost (see instructions)	0	203,154	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		18,996	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		33,398	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		203,154	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,484	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		208,638	22.00
23.00	Allowable bad debts (see instructions)		4,812	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		3,128	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		4,701	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)		211,766	26.00
26.01	Sequestration adjustment (see instructions)		4,235	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		233,357	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)		-25,826	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: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-4

Component CCN: 14-3438 | Date/Time Prepared: 11/20/2023 11:03 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)	596,486	596,486	596,486	596,486	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000939	0.002444	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	560	1,458	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	11,476	3,704	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	12,036	5,162	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	631,577	631,577	631,577	631,577	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	957,817	957,817	957,817	957,817	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.019057	0.008173	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	18,253	7,828	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	30,289	12,990	0	0	10.00
11.00	Total number of injections/infusions (from your records)	58	151	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	522.22	86.03	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	12	19	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)	6,267	1,635	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)		43,279	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)		7,902	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-4

Component CCN: 14-3495 | Date/Time Prepared: 11/20/2023 11:03 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)	3,275,331	3,275,331	3,275,331	3,275,331	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000468	0.001901	0.000580	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,533	6,226	1,900	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	31,547	14,982	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	33,080	21,208	1,900	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,640,470	3,640,470	3,640,470	3,640,470	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	5,300,780	5,300,780	5,300,780	5,300,780	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.009087	0.005826	0.000522	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	48,168	30,882	2,767	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	81,248	52,090	4,667	0	10.00
11.00	Total number of injections/infusions (from your records)	154	626	191	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	527.58	83.21	24.43	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	34	102	36	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	17,938	8,487	879	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)		138,005	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)		27,304	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1301 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-4

Component CCN: 14-8566 | Date/Time Prepared: 11/20/2023 11:03 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)	563,382	563,382	563,382	563,382	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000704	0.003520	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	397	1,983	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	8,264	6,330	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	8,661	8,313	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	602,370	602,370	602,370	602,370	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	722,171	722,171	722,171	722,171	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.014378	0.013800	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	10,383	9,966	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	19,044	18,279	0	0	10.00
11.00	Total number of injections/infusions (from your records)	40	200	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	476.10	91.40	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	60	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	5,484	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)		37,323	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)		5,484	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1301 Component CCN: 14-3438	Period: From 07/01/2022 To 06/30/2023	Worksheet M-5 Date/Time Prepared: 11/20/2023 11:03 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		101,841	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		101,841	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		68,817	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		170,658	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1301 Component CCN: 14-3495	Period: From 07/01/2022 To 06/30/2023	Worksheet M-5 Date/Time Prepared: 11/20/2023 11:03 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		745,940	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		745,940	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		27,544	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		773,484	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1301 Component CCN: 14-8566	Period: From 07/01/2022 To 06/30/2023	Worksheet M-5 Date/Time Prepared: 11/20/2023 11:03 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		233,357	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		233,357	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		25,826	6.02
7.00	Total Medicare program liability (see instructions)		207,531	7.00

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