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: 14-0294	Period: From 01/14/2023 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/28/2024 1:00 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/28/2024 Time: 1:00 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CROSSROADS COMMUNITY HOSPITAL (14-0294) for the cost reporting period beginning 01/14/2023 and ending 09/30/2023 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	Amber Lipe		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	Amber Lipe			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-111,042	-80,699	0	634,215	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	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		8,243		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-133,579		0	10.01
200.00	TOTAL	0	-111,042	-206,035	0	634,215	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2024 1:00 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 8 DOCTORS PARK ROAD	PO Box:			1.00
2.00	City: MT VERNON	State: IL	Zip Code: 62864	County: JEFFERSON	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	CROSSROADS COMMUNITY HOSPITAL	140294	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	CROSSROADS COMMUNITY HOSPITAL	14U294	99914		04/12/1989	N	P	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	CROSSROADS FAMILY MED OF WAYNE CITY	148523	99914		11/20/2019	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	CROSSROADS FAMILY MED OF MT. VERNON	148605	99914		07/19/2013	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/14/2023	09/30/2023	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.	Y	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	Y		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/28/2024 1:00 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	5	29	0	0	177	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1		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.	01/14/2023	09/30/2023	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: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2024 1:00 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2024 1:00 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0294	Period: From 01/14/2023 To 09/30/2023	Worksheet S-2 Part I Date/Time Prepared: 2/28/2024 1:00 pm

		1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)		
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?		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.	N	0	88.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2024 1:00 pm

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		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)			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)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/28/2024 1:00 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	45,562	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	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	N	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0778	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: DEACONESS HEALTH SYSTEM	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 08001	141.00
142.00	Street: 600 MARY STREET	PO Box:		142.00
143.00	City: EVANSVILLE	State: IN	Zip Code: 47710	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: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2024 1:00 pm

					1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	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)		9.99	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: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/28/2024 1:00 pm

		Y/N	Date	
		1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	Y	01/14/2023	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)	Y			3.00

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		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)	Y	02/11/2024	Y	02/11/2024	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: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part II Date/Time Prepared: 2/28/2024 1:00 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		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.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		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.		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		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		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.		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.		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.		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.		35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DANIELLE	METZGER-CUNDIFF	41.00
42.00	Enter the employer/company name of the cost report preparer.	DEACONESS HEALTH SYSTEM		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	812-450-7423	DANIELLE.METZGER-CUNDIFF@DEACONESS.C	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0294	Period: From 01/14/2023 To 09/30/2023	Worksheet S-2 Part II Date/Time Prepared: 2/28/2024 1:00 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT SUPERVISOR		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: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 2/28/2024 1:00 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	40	10,400	0.00	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)		40	10,400	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	1,820	0.00	0	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)		47	12,220	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		47				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: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/28/2024 1:00 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	422	0	1,014			1.00
2.00	HMO and other (see instructions)	134	211				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	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	422	0	1,014			7.00
8.00	INTENSIVE CARE UNIT	2	0	11			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)	424	0	1,025	0.00	108.51	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			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	1,369	0	4,972	0.00	4.36	26.00
26.01	RURAL HEALTH CLINIC II	2,549	0	9,365	0.00	11.53	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	124.40	27.00
28.00	Observation Bed Days		0	432			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/28/2024 1:00 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	159	0	414	1.00
2.00	HMO and other (see instructions)			47	83		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	159	0	414	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part II | Date/Time Prepared: 2/28/2024 1:00 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	9,214,434	-111,606	9,102,828	258,747.70	35.18	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		2,763	65,835	68,598	1,054.64	65.04	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		911,393	0	911,393	8,760.39	104.04	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		37,944	0	37,944	267.75	141.71	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		1,120,893	0	1,120,893	34,345.31	32.64	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		1,886,432	0	1,886,432			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		5,082	0	5,082			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		296,081	0	296,081			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part II Date/Time Prepared: 2/28/2024 1:00 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	119,595	-1,157	118,438	4,062.09	29.16	26.00
27.00	Administrative & General	5.00	1,129,021	-80,051	1,048,970	39,664.80	26.45	27.00
28.00	Administrative & General under contract (see inst.)		50,188	0	50,188	2,037.24	24.64	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	177,309	0	177,309	4,527.71	39.16	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	278,341	-3,115	275,226	16,347.53	16.84	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		259,623	0	259,623	10,122.67	25.65	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	291,857	0	291,857	5,554.48	52.54	38.00
39.00	Central Services and Supply	14.00	207,098	-846	206,252	3,727.19	55.34	39.00
40.00	Pharmacy	15.00	282,859	-344	282,515	4,938.75	57.20	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	74,966	-18	74,948	1,867.75	40.13	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part III Date/Time Prepared: 2/28/2024 1:00 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		9,524,245	-111,606	9,412,639	270,907.61	34.74	1.00
2.00	Excluded area salaries (see instructions)		2,763	65,835	68,598	1,054.64	65.04	2.00
3.00	Subtotal salaries (line 1 minus line 2)		9,521,482	-177,441	9,344,041	269,852.97	34.63	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,070,230	0	2,070,230	43,373.45	47.73	4.00
5.00	Subtotal wage-related costs (see inst.)		2,182,513	0	2,182,513	0.00	23.36	5.00
6.00	Total (sum of lines 3 thru 5)		13,774,225	-177,441	13,596,784	313,226.42	43.41	6.00
7.00	Total overhead cost (see instructions)		2,870,857	-85,531	2,785,326	92,850.21	30.00	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part IV Date/Time Prepared: 2/28/2024 1:00 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	7,011	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	1,139,828	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	15,188	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	1,302	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-16	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	-23	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	6,003	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	650,477	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	71,744	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,891,514	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part V | Date/Time Prepared: 2/28/2024 1:00 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	911,393	1,891,514	1.00
2.00	Hospital	911,393	1,891,514	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0294 | Component CCN: 14-8523 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/28/2024 1:00 pm

			RHC I	Cost
			1.00	
	Clinic Address and Identification			
1.00	Street		1209 WEST ROBINSON	1.00
		City	State	ZIP Code
		1.00	2.00	3.00
2.00	City, State, ZIP Code, County	WAYNE CITY	IL	62895 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			07:30	17:00	07:30	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		WAYNE				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	07:30	17:00	07:30	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0294
Component CCN: 14-8523

Period:
From 01/14/2023
To 09/30/2023

Worksheet S-8
Date/Time Prepared:
2/28/2024 1:00 pm

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:30	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0294 | Component CCN: 14-8605 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/28/2024 1:00 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			4101 NORTH WATER TOWER PLACE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MT VERNON		IL	62864	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			07:30	17:00	07:30	11.00

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

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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	07:30	17:00	07:30	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0294
Component CCN: 14-8605

Period:
From 01/14/2023
To 09/30/2023

Worksheet S-8

Date/Time Prepared:
2/28/2024 1:00 pm

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:30	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0294	Period: From 01/14/2023 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/28/2024 1:00 pm

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.172404	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,532,301	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	529,225	5.00
6.00	Medicaid charges	48,348,631	6.00
7.00	Medicaid cost (line 1 times line 6)	8,335,497	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	5,273,971	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	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 (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	5,273,971	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	1,192,774	0	1,192,774	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	205,639	0	205,639	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 (see instructions)	205,639	0	205,639	23.00

		1.00	
24.00	Does the amount on line 20 col. 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
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	10,546	26.00
27.00	Medicare reimbursable bad debts (see instructions)	6,855	27.00
27.01	Medicare allowable bad debts (see instructions)	10,546	27.01
28.00	Non-Medicare bad debt amount (see instructions)	0	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	3,691	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	209,330	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,483,301	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0294	Period: From 01/14/2023 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/28/2024 1:00 pm

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.158914	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		5.00
6.00	Medicaid charges		6.00
7.00	Medicaid cost (line 1 times line 6)		7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP		9.00
10.00	Stand-alone CHIP charges		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		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)		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		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		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	1,192,774	0	1,192,774	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	189,548	0	189,548	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 (see instructions)	189,548	0	189,548	23.00

		1.00	
24.00	Does the amount on line 20 col. 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
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	10,546	26.00
27.00	Medicare reimbursable bad debts (see instructions)	6,855	27.00
27.01	Medicare allowable bad debts (see instructions)	10,546	27.01
28.00	Non-Medicare bad debt amount (see instructions)	0	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	3,691	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	193,239	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	193,239	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/28/2024 1:00 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	235,968	235,968	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		519,627	519,627	64,599	584,226	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	119,595	59,784	179,379	1,162,282	1,341,661	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,129,021	16,961,639	18,090,660	-1,868,335	16,222,325	5.00
7.00	00700	OPERATION OF PLANT	177,309	927,509	1,104,818	-16,004	1,088,814	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	85,838	85,838	0	85,838	8.00
9.00	00900	HOUSEKEEPING	278,341	89,906	368,247	0	368,247	9.00
10.00	01000	DIETARY	0	486,660	486,660	-341,031	145,629	10.00
11.00	01100	CAFETERIA	0	0	0	341,031	341,031	11.00
13.00	01300	NURSING ADMINISTRATION	291,857	86,647	378,504	0	378,504	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	207,098	393,160	600,258	-231,297	368,961	14.00
15.00	01500	PHARMACY	282,859	843,421	1,126,280	-659,513	466,767	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	74,966	9,071	84,037	0	84,037	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	796,313	1,402,168	2,198,481	-5,564	2,192,917	30.00
31.00	03100	INTENSIVE CARE UNIT	33,225	125,244	158,469	-3,359	155,110	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,533,540	6,762,970	8,296,510	-2,404,725	5,891,785	50.00
51.00	05100	RECOVERY ROOM	124,493	23,652	148,145	0	148,145	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	593,097	400,848	993,945	2,545	996,490	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	775	57	832	0	832	55.00
56.00	05600	RADIOISOTOPE	0	144,038	144,038	0	144,038	56.00
57.00	05700	CT SCAN	148,073	126,106	274,179	0	274,179	57.00
58.00	05800	MRI	0	240,125	240,125	0	240,125	58.00
60.00	06000	LABORATORY	554,432	628,314	1,182,746	16,680	1,199,426	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	51,593	51,593	0	51,593	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	274,844	57,469	332,313	-2,768	329,545	65.00
66.00	06600	PHYSICAL THERAPY	353,372	86,171	439,543	2,872	442,415	66.00
67.00	06700	OCCUPATIONAL THERAPY	84,499	50,549	135,048	0	135,048	67.00
68.00	06800	SPEECH PATHOLOGY	50,300	3,795	54,095	0	54,095	68.00
69.00	06900	ELECTROCARDIOLOGY	13,671	1,686	15,357	0	15,357	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	343,992	343,992	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,306,339	2,306,339	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	659,513	659,513	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.99	07699	LITHOTRIPSY	0	33,200	33,200	0	33,200	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	371,600	127,518	499,118	116,779	615,897	88.00
88.01	08801	RURAL HEALTH CLINIC II	770,544	308,330	1,078,874	88,597	1,167,471	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SLEEP SERVICES	67,726	38,642	106,368	0	106,368	90.01
91.00	09100	EMERGENCY	880,121	1,297,629	2,177,750	-8,711	2,169,039	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,211,671	32,373,366	41,585,037	-200,110	41,384,927	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07955	OTHER NRCC	2,763	20,360	23,123	0	23,123	194.00
194.01	07951	MARKETING	0	0	0	200,110	200,110	194.01
194.02	07954	OTHER FACILITES	0	1,164	1,164	0	1,164	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	9,214,434	32,394,890	41,609,324	0	41,609,324	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/28/2024 1:00 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	235,968		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-947	583,279		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	761,420	2,103,081		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,340,258	9,882,067		5.00
7.00	00700	OPERATION OF PLANT	248,801	1,337,615		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	54,089	139,927		8.00
9.00	00900	HOUSEKEEPING	119,615	487,862		9.00
10.00	01000	DIETARY	68,565	214,194		10.00
11.00	01100	CAFETERIA	-37,907	303,124		11.00
13.00	01300	NURSING ADMINISTRATION	13,067	391,571		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	83,675	452,636		14.00
15.00	01500	PHARMACY	191,135	657,902		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,724	4,724		16.00
17.00	01700	SOCIAL SERVICE	149,827	233,864		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-892,214	1,300,703		30.00
31.00	03100	INTENSIVE CARE UNIT	-64,795	90,315		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,336,806	4,554,979		50.00
51.00	05100	RECOVERY ROOM	0	148,145		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-36,826	959,664		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	832		55.00
56.00	05600	RADIOISOTOPE	0	144,038		56.00
57.00	05700	CT SCAN	0	274,179		57.00
58.00	05800	MRI	0	240,125		58.00
60.00	06000	LABORATORY	0	1,199,426		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	51,593		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	329,545		65.00
66.00	06600	PHYSICAL THERAPY	0	442,415		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	135,048		67.00
68.00	06800	SPEECH PATHOLOGY	0	54,095		68.00
69.00	06900	ELECTROCARDIOLOGY	0	15,357		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	343,992		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,306,339		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	659,513		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.99	07699	LITHOTRIPSY	0	33,200		76.99
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	615,897		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,167,471		88.01
90.00	09000	CLINIC	0	0		90.00
90.01	09001	SLEEP SERVICES	-2,332	104,036		90.01
91.00	09100	EMERGENCY	-989,077	1,179,962		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,006,244	33,378,683		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		192.00
194.00	07955	OTHER NRCC	0	23,123		194.00
194.01	07951	MARKETING	0	200,110		194.01
194.02	07954	OTHER FACILITES	0	1,164		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,006,244	33,603,080		200.00

RECLASSIFICATIONS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/28/2024 1:00 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,162,282		1.00
	0		0	1,162,282		
	B - OXYGEN SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	16,004		1.00
2.00		0.00	0	0		2.00
	0		0	16,004		
	C - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	235,968		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	64,599		2.00
3.00		0.00	0	0		3.00
	0		0	300,567		
	D - MARKETING					
1.00	MARKETING	194.01	65,835	0		1.00
2.00		0.00	0	0		2.00
3.00	MARKETING	194.01	0	134,275		3.00
4.00		0.00	0	0		4.00
	0		65,835	134,275		
	E - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	327,988		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,306,339		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	RADIOLOGY-DIAGNOSTIC	54.00	0	2,545		7.00
8.00	LABORATORY	60.00	0	16,680		8.00
9.00		0.00	0	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	2,872		10.00
11.00		0.00	0	0		11.00
	0		0	2,656,424		
	F - COST OF DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	659,513		1.00
2.00		0.00	0	0		2.00
	0		0	659,513		
	G - DIETARY					
1.00	CAFETERIA	11.00	0	341,031		1.00
2.00		0.00	0	0		2.00
	0		0	341,031		
	H - DISABILITY					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,157		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	14,216		2.00
3.00	HOUSEKEEPING	9.00	0	3,115		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	846		4.00
5.00	PHARMACY	15.00	0	344		5.00
6.00	SOCIAL SERVICE	17.00	0	18		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	9,222		7.00
8.00	OPERATING ROOM	50.00	0	34,555		8.00
9.00	RECOVERY ROOM	51.00	0	2,607		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,629		10.00
11.00	CT SCAN	57.00	0	6,965		11.00
12.00	LABORATORY	60.00	0	9,102		12.00
13.00	RESPIRATORY THERAPY	65.00	0	2,197		13.00
14.00	PHYSICAL THERAPY	66.00	0	1,710		14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	2,317		15.00
16.00	RURAL HEALTH CLINIC	88.00	0	4,608		16.00
17.00	RURAL HEALTH CLINIC II	88.01	0	8,323		17.00
18.00	SLEEP SERVICES	90.01	0	170		18.00
19.00	EMERGENCY	91.00	0	4,505		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00

RECLASSIFICATIONS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/28/2024 1:00 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
38.00		0.00	0	0		38.00
	TOTALS		0	111,606		
	I - RHC					
1.00	RURAL HEALTH CLINIC	88.00	0	116,779		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	88,597		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	205,376		
500.00	Grand Total: Increases		65,835	5,587,078		500.00

RECLASSIFICATIONS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/28/2024 1:00 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,162,282	0		1.00
	0		0	1,162,282			
	B - OXYGEN SUPPLY						
1.00		0.00	0	0	0		1.00
2.00	OPERATION OF PLANT	7.00	0	16,004	0		2.00
	0		0	16,004			
	C - OTHER CAPITAL COSTS						
1.00		0.00	0	0	12		1.00
2.00		0.00	0	0	13		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	300,567	12		3.00
	0		0	300,567			
	D - MARKETING						
1.00		0.00	0	0	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	65,835	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	134,275	0		4.00
	0		65,835	134,275			
	E - MEDICAL SUPPLIES						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	231,297	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	5,564	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	3,359	0		5.00
6.00	OPERATING ROOM	50.00	0	2,404,725	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	2,768	0		9.00
10.00		0.00	0	0	0		10.00
11.00	EMERGENCY	91.00	0	8,711	0		11.00
	0		0	2,656,424			
	F - COST OF DRUGS						
1.00		0.00	0	0	0		1.00
2.00	PHARMACY	15.00	0	659,513	0		2.00
	0		0	659,513			
	G - DIETARY						
1.00		0.00	0	0	0		1.00
2.00	DIETARY	10.00	0	341,031	0		2.00
	0		0	341,031			
	H - DISABILITY						
1.00		0.00	0	0	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
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
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,157	0	0		20.00
21.00	ADMINISTRATIVE & GENERAL	5.00	14,216	0	0		21.00
22.00	HOUSEKEEPING	9.00	3,115	0	0		22.00
23.00	CENTRAL SERVICES & SUPPLY	14.00	846	0	0		23.00
24.00	PHARMACY	15.00	344	0	0		24.00
25.00	SOCIAL SERVICE	17.00	18	0	0		25.00
26.00	ADULTS & PEDIATRICS	30.00	9,222	0	0		26.00
27.00	OPERATING ROOM	50.00	34,555	0	0		27.00
28.00	RECOVERY ROOM	51.00	2,607	0	0		28.00
29.00	RADIOLOGY-DIAGNOSTIC	54.00	5,629	0	0		29.00
30.00	CT SCAN	57.00	6,965	0	0		30.00
31.00	LABORATORY	60.00	9,102	0	0		31.00
32.00	RESPIRATORY THERAPY	65.00	2,197	0	0		32.00
33.00	PHYSICAL THERAPY	66.00	1,710	0	0		33.00
34.00	OCCUPATIONAL THERAPY	67.00	2,317	0	0		34.00

RECLASSIFICATIONS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/28/2024 1:00 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
35.00	RURAL HEALTH CLINIC	88.00	4,608	0	0		35.00
36.00	RURAL HEALTH CLINIC II	88.01	8,323	0	0		36.00
37.00	SLEEP SERVICES	90.01	170	0	0		37.00
38.00	EMERGENCY	91.00	4,505	0	0		38.00
	TOTALS		111,606	0			
	I - RHC						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	205,376	0		3.00
	TOTALS		0	205,376			
500.00	Grand Total: Decreases		177,441	5,475,472			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 2/28/2024 1:00 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,640,000	0	0	0	1,640,000	1.00
2.00	Land Improvements	162,111	0	0	0	162,111	2.00
3.00	Buildings and Fixtures	6,697,204	0	0	0	6,697,204	3.00
4.00	Building Improvements	77,728	15,267	0	15,267	0	4.00
5.00	Fixed Equipment	188,119	0	0	0	172,979	5.00
6.00	Movable Equipment	4,916,324	0	0	0	409,366	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	13,681,486	15,267	0	15,267	9,081,660	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	13,681,486	15,267	0	15,267	9,081,660	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	92,995	0	4.00
5.00	Fixed Equipment	15,140	0	5.00
6.00	Movable Equipment	4,506,958	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	4,615,093	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	4,615,093	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 2/28/2024 1:00 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	519,627	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	519,627	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	519,627		2.00
3.00	Total (sum of lines 1-2)	0	519,627		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 2/28/2024 1:00 pm

	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	92,995	0	92,995	0.020150	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,522,098	0	4,522,098	0.979850	0	2.00
3.00	Total (sum of lines 1-2)	4,615,093	0	4,615,093	1.000000	0	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	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	518,680	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	518,680	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	0	235,968	0	0	235,968	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	64,599	0	583,279	2.00
3.00	Total (sum of lines 1-2)	0	235,968	64,599	0	819,247	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/28/2024 1:00 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	A	-466,524	ADMINISTRATIVE & GENERAL	5.00	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	-42,278	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,322,050			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1,784,850			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-37,907	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	0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	0	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	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	OTHER MISCELLANEOUS REVENUE	B	-11,893	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/28/2024 1:00 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	TELEPHONE DEPRECIATION COST	A	-947	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.01
33.02	TELEVISION EXPENSE	A	-8,861	OPERATION OF PLANT	7.00	0	33.02
33.03	PHYSICIAN RECRUITING	A	-62,843	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	LOBBYING EXPENSE	A	-8,121	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	SPECIAL EVENTS	A	-25,671	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	ILLINOIS PROVIDER TAX	A	-2,174,529	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	HOME OFFICE	A	-59,770	ADMINISTRATIVE & GENERAL	5.00	0	33.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,006,244				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/28/2024 1:00 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	STAFFING	704,227	3,982,224	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	FACILITY RENT	1,071,750	2,306,470	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	853,858	92,438	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	1,547,975	523,887	4.00
4.01	7.00	OPERATION OF PLANT	HOME OFFICE	281,255	23,593	4.01
4.02	8.00	LAUNDRY & LINEN SERVICE	HOME OFFICE	54,089	0	4.02
4.03	9.00	HOUSEKEEPING	HOME OFFICE	119,615	0	4.03
4.04	10.00	DIETARY	HOME OFFICE	68,565	0	4.04
4.05	13.00	NURSING ADMINISTRATION	HOME OFFICE	13,067	0	4.05
4.06	14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE	83,675	0	4.06
4.07	15.00	PHARMACY	HOME OFFICE	191,135	0	4.07
4.08	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	4,724	0	4.08
4.09	17.00	SOCIAL SERVICE	HOME OFFICE	154,367	4,540	4.09
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,148,302	6,933,152	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-0294	Period: From 01/14/2023 To 09/30/2023	Worksheet A-8-1 Date/Time Prepared: 2/28/2024 1:00 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-3,277,997	0		1.00
2.00	-1,234,720	9		2.00
3.00	761,420	9		3.00
4.00	1,024,088	0		4.00
4.01	257,662	0		4.01
4.02	54,089	0		4.02
4.03	119,615	0		4.03
4.04	68,565	0		4.04
4.05	13,067	0		4.05
4.06	83,675	0		4.06
4.07	191,135	0		4.07
4.08	4,724	0		4.08
4.09	149,827	0		4.09
5.00	-1,784,850			5.00

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

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

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

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

6.00	HEALTH SYSTEM		6.00
7.00	HEALTH SYSTEM		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 2/28/2024 1:00 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	892,214	892,214	0	211,500	0	1.00
2.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	64,795	64,795	0	211,500	0	2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	196,426	196,426	0	246,400	0	3.00
4.00	50.00	AGGREGATE-OPERATING ROOM	1,140,380	1,140,380	0	246,400	0	4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	18,197	197	18,000	271,900	98	5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	31,440	31,440	0	271,900	0	6.00
7.00	60.00	AGGREGATE-LABORATORY	5,600	0	5,600	260,300	55	7.00
8.00	90.01	AGGREGATE-SLEEP SERVICES	12,500	0	12,500	211,500	100	8.00
9.00	91.00	AGGREGATE-EMERGENCY	990,602	988,758	1,844	211,500	15	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,352,154	3,314,210	37,944		268	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	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	3.00
4.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	12,811	641	0	0	0	5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	AGGREGATE-LABORATORY	6,883	344	0	0	0	7.00
8.00	90.01	AGGREGATE-SLEEP SERVICES	10,168	508	0	0	0	8.00
9.00	91.00	AGGREGATE-EMERGENCY	1,525	76	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			31,387	1,569	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	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	892,214		1.00
2.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	64,795		2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	196,426		3.00
4.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	1,140,380		4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	12,811	5,189	5,386		5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	31,440		6.00
7.00	60.00	AGGREGATE-LABORATORY	0	6,883	0	0		7.00
8.00	90.01	AGGREGATE-SLEEP SERVICES	0	10,168	2,332	2,332		8.00
9.00	91.00	AGGREGATE-EMERGENCY	0	1,525	319	989,077		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	31,387	7,840	3,322,050		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/28/2024 1:00 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	235,968	235,968				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	583,279		583,279			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,103,081	1,926	4,761	2,109,768		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,882,067	60,614	149,832	246,325	10,338,838	5.00
7.00	00700	OPERATION OF PLANT	1,337,615	12,534	30,983	41,637	1,422,769	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	139,927	1,327	3,281	0	144,535	8.00
9.00	00900	HOUSEKEEPING	487,862	9,339	23,084	64,630	584,915	9.00
10.00	01000	DIETARY	214,194	4,025	9,949	0	228,168	10.00
11.00	01100	CAFETERIA	303,124	5,545	13,705	0	322,374	11.00
13.00	01300	NURSING ADMINISTRATION	391,571	0	0	68,536	460,107	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	452,636	0	0	48,433	501,069	14.00
15.00	01500	PHARMACY	657,902	2,205	5,450	66,342	731,899	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,724	2,392	5,914	0	13,030	16.00
17.00	01700	SOCIAL SERVICE	233,864	224	553	17,600	252,241	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,300,703	46,407	114,712	184,829	1,646,651	30.00
31.00	03100	INTENSIVE CARE UNIT	90,315	9,062	22,400	7,802	129,579	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,554,979	35,734	88,330	352,001	5,031,044	50.00
51.00	05100	RECOVERY ROOM	148,145	683	1,688	28,622	179,138	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	959,664	13,294	32,861	137,953	1,143,772	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	832	0	0	182	1,014	55.00
56.00	05600	RADIOISOTOPE	144,038	668	1,652	0	146,358	56.00
57.00	05700	CT SCAN	274,179	796	1,967	33,136	310,078	57.00
58.00	05800	MRI	240,125	0	0	0	240,125	58.00
60.00	06000	LABORATORY	1,199,426	5,965	14,745	128,058	1,348,194	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	51,593	344	850	0	52,787	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	329,545	3,061	7,566	64,025	404,197	65.00
66.00	06600	PHYSICAL THERAPY	442,415	392	969	82,579	526,355	66.00
67.00	06700	OCCUPATIONAL THERAPY	135,048	0	0	19,298	154,346	67.00
68.00	06800	SPEECH PATHOLOGY	54,095	0	0	11,812	65,907	68.00
69.00	06900	ELECTROCARDIOLOGY	15,357	1,688	4,172	3,210	24,427	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	343,992	0	0	0	343,992	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,306,339	0	0	0	2,306,339	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	659,513	0	0	0	659,513	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.99	07699	LITHOTRIPSY	33,200	0	0	0	33,200	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	615,897	0	0	86,179	702,076	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,167,471	0	0	178,989	1,346,460	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SLEEP SERVICES	104,036	1,258	3,108	15,864	124,266	90.01
91.00	09100	EMERGENCY	1,179,962	16,021	39,600	205,617	1,441,200	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,378,683	235,504	582,132	2,093,659	33,360,963	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	464	1,147	0	1,611	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07955	OTHER NRCC	23,123	0	0	649	23,772	194.00
194.01	07951	MARKETING	200,110	0	0	15,460	215,570	194.01
194.02	07954	OTHER FACILITES	1,164	0	0	0	1,164	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	33,603,080	235,968	583,279	2,109,768	33,603,080	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/28/2024 1:00 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,338,838					5.00
7.00	00700	OPERATION OF PLANT	632,291	2,055,060				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	64,233	16,952	225,720			8.00
9.00	00900	HOUSEKEEPING	259,941	119,282	0	964,138		9.00
10.00	01000	DIETARY	101,400	51,410	0	25,832	406,810	10.00
11.00	01100	CAFETERIA	143,266	70,820	0	35,584	0	11.00
13.00	01300	NURSING ADMINISTRATION	204,476	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	222,680	0	0	0	0	14.00
15.00	01500	PHARMACY	325,263	28,162	0	14,150	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,791	30,557	0	15,354	0	16.00
17.00	01700	SOCIAL SERVICE	112,098	2,856	0	1,435	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	731,787	592,755	74,491	297,836	402,460	30.00
31.00	03100	INTENSIVE CARE UNIT	57,586	115,750	13,541	58,160	4,350	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,235,837	456,427	45,143	229,338	0	50.00
51.00	05100	RECOVERY ROOM	79,611	8,722	0	4,382	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	508,303	169,801	13,541	85,319	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	451	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	65,043	8,538	0	4,290	0	56.00
57.00	05700	CT SCAN	137,801	10,165	0	5,108	0	57.00
58.00	05800	MRI	106,714	0	0	0	0	58.00
60.00	06000	LABORATORY	599,150	76,194	0	38,285	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	23,459	4,392	0	2,207	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	179,629	39,095	6,773	19,644	0	65.00
66.00	06600	PHYSICAL THERAPY	233,917	5,006	0	2,515	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	68,593	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	29,290	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,856	21,559	0	10,833	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	152,873	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,024,958	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	293,094	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.99	07699	LITHOTRIPSY	14,754	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	312,009	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	598,379	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SLEEP SERVICES	55,225	16,062	0	8,070	0	90.01
91.00	09100	EMERGENCY	640,482	204,628	72,231	102,818	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,231,240	2,049,133	225,720	961,160	406,810	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	716	5,927	0	2,978	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07955	OTHER NRCC	10,564	0	0	0	0	194.00
194.01	07951	MARKETING	95,801	0	0	0	0	194.01
194.02	07954	OTHER FACILITES	517	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	10,338,838	2,055,060	225,720	964,138	406,810	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/28/2024 1:00 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	572,044					11.00
13.00	01300	NURSING ADMINISTRATION	16,363	680,946				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,970	19,537	754,256			14.00
15.00	01500	PHARMACY	14,525	26,684	15,858	1,156,541		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	64,732	16.00
17.00	01700	SOCIAL SERVICE	5,516	7,072	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,454	75,121	9,344	0	752	30.00
31.00	03100	INTENSIVE CARE UNIT	1,961	3,134	676	0	11	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	116,383	144,667	294,669	0	20,240	50.00
51.00	05100	RECOVERY ROOM	8,948	11,744	2,162	0	1,494	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,006	55,950	5,017	0	3,602	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	73	0	0	306	55.00
56.00	05600	RADIOISOTOPE	0	0	861	0	423	56.00
57.00	05700	CT SCAN	11,889	13,969	4,662	0	7,578	57.00
58.00	05800	MRI	0	0	0	0	1,460	58.00
60.00	06000	LABORATORY	52,154	52,303	12,379	0	10,590	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	125	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	90	64.00
65.00	06500	RESPIRATORY THERAPY	21,389	25,928	3,657	0	402	65.00
66.00	06600	PHYSICAL THERAPY	25,189	33,336	303	0	1,813	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,028	7,971	191	0	506	67.00
68.00	06800	SPEECH PATHOLOGY	4,474	4,745	0	0	106	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,290	11	0	659	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	51,088	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	335,354	0	6,771	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,156,541	686	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	119	76.97
76.99	07699	LITHOTRIPSY	0	0	0	0	212	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	27,088	35,055	2,145	0	449	88.00
88.01	08801	RURAL HEALTH CLINIC II	71,705	72,690	3,969	0	767	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SLEEP SERVICES	5,883	6,389	1,527	0	258	90.01
91.00	09100	EMERGENCY	53,993	83,027	9,832	0	5,313	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	568,918	680,685	753,705	1,156,541	64,732	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07955	OTHER NRCC	0	261	523	0	0	194.00
194.01	07951	MARKETING	3,126	0	0	0	0	194.01
194.02	07954	OTHER FACILITES	0	0	28	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)	572,044	680,946	754,256	1,156,541	64,732	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/28/2024 1:00 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	381,218					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	377,127	4,273,778	0	4,273,778		30.00
31.00	03100	INTENSIVE CARE UNIT	4,091	388,839	0	388,839		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	8,573,748	0	8,573,748		50.00
51.00	05100	RECOVERY ROOM	0	296,201	0	296,201		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,032,311	0	2,032,311		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	1,844	0	1,844		55.00
56.00	05600	RADIOISOTOPE	0	225,513	0	225,513		56.00
57.00	05700	CT SCAN	0	501,250	0	501,250		57.00
58.00	05800	MRI	0	348,299	0	348,299		58.00
60.00	06000	LABORATORY	0	2,189,249	0	2,189,249		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	82,970	0	82,970		63.00
64.00	06400	INTRAVENOUS THERAPY	0	90	0	90		64.00
65.00	06500	RESPIRATORY THERAPY	0	700,714	0	700,714		65.00
66.00	06600	PHYSICAL THERAPY	0	828,434	0	828,434		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	239,635	0	239,635		67.00
68.00	06800	SPEECH PATHOLOGY	0	104,522	0	104,522		68.00
69.00	06900	ELECTROCARDIOLOGY	0	69,635	0	69,635		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	547,953	0	547,953		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,673,422	0	3,673,422		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,109,834	0	2,109,834		73.00
76.97	07697	CARDIAC REHABILITATION	0	119	0	119		76.97
76.99	07699	LITHOTRIPSY	0	48,166	0	48,166		76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,078,822	0	1,078,822		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,093,970	0	2,093,970		88.01
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	SLEEP SERVICES	0	217,680	0	217,680		90.01
91.00	09100	EMERGENCY	0	2,613,524	0	2,613,524		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	381,218	33,240,522	0	33,240,522		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	11,232	0	11,232		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.00
194.00	07955	OTHER NRCC	0	35,120	0	35,120		194.00
194.01	07951	MARKETING	0	314,497	0	314,497		194.01
194.02	07954	OTHER FACILITES	0	1,709	0	1,709		194.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	381,218	33,603,080	0	33,603,080		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/28/2024 1:00 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,926	4,761	6,687	6,687	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	60,614	149,832	210,446	780	5.00
7.00	00700	OPERATION OF PLANT	0	12,534	30,983	43,517	132	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,327	3,281	4,608	0	8.00
9.00	00900	HOUSEKEEPING	0	9,339	23,084	32,423	205	9.00
10.00	01000	DIETARY	0	4,025	9,949	13,974	0	10.00
11.00	01100	CAFETERIA	0	5,545	13,705	19,250	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	217	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	153	14.00
15.00	01500	PHARMACY	0	2,205	5,450	7,655	210	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,392	5,914	8,306	0	16.00
17.00	01700	SOCIAL SERVICE	0	224	553	777	56	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	46,407	114,712	161,119	586	30.00
31.00	03100	INTENSIVE CARE UNIT	0	9,062	22,400	31,462	25	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	35,734	88,330	124,064	1,118	50.00
51.00	05100	RECOVERY ROOM	0	683	1,688	2,371	91	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,294	32,861	46,155	437	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	1	55.00
56.00	05600	RADIOISOTOPE	0	668	1,652	2,320	0	56.00
57.00	05700	CT SCAN	0	796	1,967	2,763	105	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	5,965	14,745	20,710	406	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	344	850	1,194	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,061	7,566	10,627	203	65.00
66.00	06600	PHYSICAL THERAPY	0	392	969	1,361	262	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	61	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	37	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,688	4,172	5,860	10	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	273	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	567	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SLEEP SERVICES	0	1,258	3,108	4,366	50	90.01
91.00	09100	EMERGENCY	0	16,021	39,600	55,621	651	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	235,504	582,132	817,636	6,636	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	464	1,147	1,611	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07955	OTHER NRCC	0	0	0	0	2	194.00
194.01	07951	MARKETING	0	0	0	0	49	194.01
194.02	07954	OTHER FACILITES	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	235,968	583,279	819,247	6,687	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/28/2024 1:00 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	211,226					5.00
7.00	00700	OPERATION OF PLANT	12,917	56,566				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,312	467	6,387			8.00
9.00	00900	HOUSEKEEPING	5,310	3,283	0	41,221		9.00
10.00	01000	DIETARY	2,072	1,415	0	1,104	18,565	10.00
11.00	01100	CAFETERIA	2,927	1,949	0	1,521	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,177	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,549	0	0	0	0	14.00
15.00	01500	PHARMACY	6,645	775	0	605	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	118	841	0	656	0	16.00
17.00	01700	SOCIAL SERVICE	2,290	79	0	61	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,950	16,317	2,108	12,736	18,366	30.00
31.00	03100	INTENSIVE CARE UNIT	1,176	3,186	383	2,487	199	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,689	12,563	1,277	9,805	0	50.00
51.00	05100	RECOVERY ROOM	1,626	240	0	187	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,384	4,674	383	3,648	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	9	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	1,329	235	0	183	0	56.00
57.00	05700	CT SCAN	2,815	280	0	218	0	57.00
58.00	05800	MRI	2,180	0	0	0	0	58.00
60.00	06000	LABORATORY	12,240	2,097	0	1,637	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	479	121	0	94	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,670	1,076	192	840	0	65.00
66.00	06600	PHYSICAL THERAPY	4,779	138	0	108	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,401	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	598	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	222	593	0	463	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,123	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,939	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,988	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.99	07699	LITHOTRIPSY	301	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,374	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	12,225	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SLEEP SERVICES	1,128	442	0	345	0	90.01
91.00	09100	EMERGENCY	13,085	5,632	2,044	4,396	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	209,027	56,403	6,387	41,094	18,565	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	15	163	0	127	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07955	OTHER NRCC	216	0	0	0	0	194.00
194.01	07951	MARKETING	1,957	0	0	0	0	194.01
194.02	07954	OTHER FACILITES	11	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	211,226	56,566	6,387	41,221	18,565	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/28/2024 1:00 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	25,647					11.00
13.00	01300	NURSING ADMINISTRATION	734	5,128				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	492	147	5,341			14.00
15.00	01500	PHARMACY	651	201	112	16,854		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	9,921	16.00
17.00	01700	SOCIAL SERVICE	247	53	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,935	565	66	0	116	30.00
31.00	03100	INTENSIVE CARE UNIT	88	24	5	0	2	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,218	1,091	2,087	0	3,075	50.00
51.00	05100	RECOVERY ROOM	401	88	15	0	230	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,107	421	36	0	554	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	1	0	0	47	55.00
56.00	05600	RADIOISOTOPE	0	0	6	0	65	56.00
57.00	05700	CT SCAN	533	105	33	0	1,166	57.00
58.00	05800	MRI	0	0	0	0	225	58.00
60.00	06000	LABORATORY	2,338	394	88	0	1,629	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	19	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	14	64.00
65.00	06500	RESPIRATORY THERAPY	959	195	26	0	62	65.00
66.00	06600	PHYSICAL THERAPY	1,129	251	2	0	279	66.00
67.00	06700	OCCUPATIONAL THERAPY	360	60	1	0	78	67.00
68.00	06800	SPEECH PATHOLOGY	201	36	0	0	16	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10	0	0	101	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	362	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,374	0	1,042	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	16,854	106	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	18	76.97
76.99	07699	LITHOTRIPSY	0	0	0	0	33	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,214	264	15	0	69	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,215	547	28	0	118	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SLEEP SERVICES	264	48	11	0	40	90.01
91.00	09100	EMERGENCY	2,421	625	70	0	817	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,507	5,126	5,337	16,854	9,921	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07955	OTHER NRCC	0	2	4	0	0	194.00
194.01	07951	MARKETING	140	0	0	0	0	194.01
194.02	07954	OTHER FACILITES	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	25,647	5,128	5,341	16,854	9,921	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/28/2024 1:00 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	3,563					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,525	233,389	0	233,389		30.00
31.00	03100	INTENSIVE CARE UNIT	38	39,075	0	39,075		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	205,987	0	205,987		50.00
51.00	05100	RECOVERY ROOM	0	5,249	0	5,249		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	68,799	0	68,799		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	58	0	58		55.00
56.00	05600	RADIOISOTOPE	0	4,138	0	4,138		56.00
57.00	05700	CT SCAN	0	8,018	0	8,018		57.00
58.00	05800	MRI	0	2,405	0	2,405		58.00
60.00	06000	LABORATORY	0	41,539	0	41,539		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	1,907	0	1,907		63.00
64.00	06400	INTRAVENOUS THERAPY	0	14	0	14		64.00
65.00	06500	RESPIRATORY THERAPY	0	17,850	0	17,850		65.00
66.00	06600	PHYSICAL THERAPY	0	8,309	0	8,309		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,961	0	1,961		67.00
68.00	06800	SPEECH PATHOLOGY	0	888	0	888		68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,259	0	7,259		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,485	0	3,485		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	24,355	0	24,355		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,948	0	22,948		73.00
76.97	07697	CARDIAC REHABILITATION	0	18	0	18		76.97
76.99	07699	LITHOTRIPSY	0	334	0	334		76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	8,209	0	8,209		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	16,700	0	16,700		88.01
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	SLEEP SERVICES	0	6,694	0	6,694		90.01
91.00	09100	EMERGENCY	0	85,362	0	85,362		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,563	814,950	0	814,950		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	1,916	0	1,916		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.00
194.00	07955	OTHER NRCC	0	224	0	224		194.00
194.01	07951	MARKETING	0	2,146	0	2,146		194.01
194.02	07954	OTHER FACILITES	0	11	0	11		194.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,563	819,247	0	819,247		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/28/2024 1:00 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	98,140					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		98,140				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	801	801	8,984,390			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,210	25,210	1,048,970	-10,338,838	23,264,242	5.00
7.00	00700	OPERATION OF PLANT	5,213	5,213	177,309	0	1,422,769	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	552	552	0	0	144,535	8.00
9.00	00900	HOUSEKEEPING	3,884	3,884	275,226	0	584,915	9.00
10.00	01000	DIETARY	1,674	1,674	0	0	228,168	10.00
11.00	01100	CAFETERIA	2,306	2,306	0	0	322,374	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	291,857	0	460,107	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	206,252	0	501,069	14.00
15.00	01500	PHARMACY	917	917	282,515	0	731,899	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	995	995	0	0	13,030	16.00
17.00	01700	SOCIAL SERVICE	93	93	74,948	0	252,241	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,301	19,301	787,091	0	1,646,651	30.00
31.00	03100	INTENSIVE CARE UNIT	3,769	3,769	33,225	0	129,579	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,862	14,862	1,498,985	0	5,031,044	50.00
51.00	05100	RECOVERY ROOM	284	284	121,886	0	179,138	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,529	5,529	587,468	0	1,143,772	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	775	0	1,014	55.00
56.00	05600	RADIOISOTOPE	278	278	0	0	146,358	56.00
57.00	05700	CT SCAN	331	331	141,108	0	310,078	57.00
58.00	05800	MRI	0	0	0	0	240,125	58.00
60.00	06000	LABORATORY	2,481	2,481	545,330	0	1,348,194	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	143	143	0	0	52,787	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,273	1,273	272,647	0	404,197	65.00
66.00	06600	PHYSICAL THERAPY	163	163	351,662	0	526,355	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	82,182	0	154,346	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	50,300	0	65,907	68.00
69.00	06900	ELECTROCARDIOLOGY	702	702	13,671	0	24,427	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	343,992	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,306,339	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	659,513	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.99	07699	LITHOTRIPSY	0	0	0	0	33,200	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	366,992	0	702,076	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	762,221	0	1,346,460	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SLEEP SERVICES	523	523	67,556	0	124,266	90.01
91.00	09100	EMERGENCY	6,663	6,663	875,616	0	1,441,200	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	97,947	97,947	8,915,792	-10,338,838	23,022,125	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	193	193	0	0	1,611	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07955	OTHER NRCC	0	0	2,763	0	23,772	194.00
194.01	07951	MARKETING	0	0	65,835	0	215,570	194.01
194.02	07954	OTHER FACILITES	0	0	0	0	1,164	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)	235,968	583,279	2,109,768		10,338,838	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.404402	5.943336	0.234826		0.444409	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			6,687		211,226	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000744		0.009079	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: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/28/2024 1:00 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	66,916					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	552	87,381				8.00
9.00	00900	HOUSEKEEPING	3,884	0	62,480			9.00
10.00	01000	DIETARY	1,674	0	1,674	4,769		10.00
11.00	01100	CAFETERIA	2,306	0	2,306	0	9,334	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	267	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	179	14.00
15.00	01500	PHARMACY	917	0	917	0	237	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	995	0	995	0	0	16.00
17.00	01700	SOCIAL SERVICE	93	0	93	0	90	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,301	28,837	19,301	4,718	1,068	30.00
31.00	03100	INTENSIVE CARE UNIT	3,769	5,242	3,769	51	32	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,862	17,476	14,862	0	1,899	50.00
51.00	05100	RECOVERY ROOM	284	0	284	0	146	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,529	5,242	5,529	0	767	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	278	0	278	0	0	56.00
57.00	05700	CT SCAN	331	0	331	0	194	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,481	0	2,481	0	851	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	143	0	143	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,273	2,622	1,273	0	349	65.00
66.00	06600	PHYSICAL THERAPY	163	0	163	0	411	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	131	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	73	68.00
69.00	06900	ELECTROCARDIOLOGY	702	0	702	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	442	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	1,170	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SLEEP SERVICES	523	0	523	0	96	90.01
91.00	09100	EMERGENCY	6,663	27,962	6,663	0	881	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,723	87,381	62,287	4,769	9,283	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	193	0	193	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07955	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	51	194.01
194.02	07954	OTHER FACILITES	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,055,060	225,720	964,138	406,810	572,044	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.711041	2.583170	15.431146	85.302999	61.286051	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	56,566	6,387	41,221	18,565	25,647	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.845328	0.073094	0.659747	3.892850	2.747697	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: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/28/2024 1:00 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	7,218,311					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	207,098	4,444,680				14.00
15.00	01500	PHARMACY	282,859	93,445	579,211			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	191,522,304		16.00
17.00	01700	SOCIAL SERVICE	74,966	0	0	0	1,025	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	796,313	55,061	0	2,225,293	1,014	30.00
31.00	03100	INTENSIVE CARE UNIT	33,225	3,982	0	32,511	11	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,533,540	1,736,423	0	59,887,997	0	50.00
51.00	05100	RECOVERY ROOM	124,493	12,743	0	4,420,974	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	593,097	29,565	0	10,657,576	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	775	0	0	903,924	0	55.00
56.00	05600	RADIOISOTOPE	0	5,072	0	1,252,413	0	56.00
57.00	05700	CT SCAN	148,073	27,470	0	22,421,378	0	57.00
58.00	05800	MRI	0	0	0	4,318,150	0	58.00
60.00	06000	LABORATORY	554,432	72,945	0	31,331,088	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	369,084	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	266,287	0	64.00
65.00	06500	RESPIRATORY THERAPY	274,844	21,550	0	1,189,957	0	65.00
66.00	06600	PHYSICAL THERAPY	353,372	1,783	0	5,362,767	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	84,499	1,126	0	1,496,255	0	67.00
68.00	06800	SPEECH PATHOLOGY	50,300	0	0	314,043	0	68.00
69.00	06900	ELECTROCARDIOLOGY	13,671	67	0	1,949,021	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	301,053	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,976,192	0	20,031,912	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	579,211	2,030,126	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	351,389	0	76.97
76.99	07699	LITHOTRIPSY	0	0	0	627,707	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	371,600	12,638	0	1,328,674	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	770,544	23,386	0	2,269,998	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SLEEP SERVICES	67,726	8,996	0	764,691	0	90.01
91.00	09100	EMERGENCY	880,121	57,937	0	15,719,089	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,215,548	4,441,434	579,211	191,522,304	1,025	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07955	OTHER NRCC	2,763	3,082	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07954	OTHER FACILITES	0	164	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)	680,946	754,256	1,156,541	64,732	381,218	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.094336	0.169699	1.996752	0.000338	371.920000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,128	5,341	16,854	9,921	3,563	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000710	0.001202	0.029098	0.000052	3.476098	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/28/2024 1:00 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,273,778		4,273,778	0	4,273,778	30.00
31.00	03100	INTENSIVE CARE UNIT	388,839		388,839	0	388,839	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,573,748		8,573,748	0	8,573,748	50.00
51.00	05100	RECOVERY ROOM	296,201		296,201	0	296,201	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,032,311		2,032,311	5,189	2,037,500	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,844		1,844	0	1,844	55.00
56.00	05600	RADIOISOTOPE	225,513		225,513	0	225,513	56.00
57.00	05700	CT SCAN	501,250		501,250	0	501,250	57.00
58.00	05800	MRI	348,299		348,299	0	348,299	58.00
60.00	06000	LABORATORY	2,189,249		2,189,249	0	2,189,249	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	82,970		82,970	0	82,970	63.00
64.00	06400	INTRAVENOUS THERAPY	90		90	0	90	64.00
65.00	06500	RESPIRATORY THERAPY	700,714	0	700,714	0	700,714	65.00
66.00	06600	PHYSICAL THERAPY	828,434	0	828,434	0	828,434	66.00
67.00	06700	OCCUPATIONAL THERAPY	239,635	0	239,635	0	239,635	67.00
68.00	06800	SPEECH PATHOLOGY	104,522	0	104,522	0	104,522	68.00
69.00	06900	ELECTROCARDIOLOGY	69,635		69,635	0	69,635	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	547,953		547,953	0	547,953	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,673,422		3,673,422	0	3,673,422	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,109,834		2,109,834	0	2,109,834	73.00
76.97	07697	CARDIAC REHABILITATION	119		119	0	119	76.97
76.99	07699	LITHOTRIPSY	48,166		48,166	0	48,166	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,078,822		1,078,822	0	1,078,822	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,093,970		2,093,970	0	2,093,970	88.01
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	SLEEP SERVICES	217,680		217,680	2,332	220,012	90.01
91.00	09100	EMERGENCY	2,613,524		2,613,524	319	2,613,843	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,276,815		1,276,815		1,276,815	92.00
200.00		Subtotal (see instructions)	34,517,337	0	34,517,337	7,840	34,525,177	200.00
201.00		Less Observation Beds	1,276,815		1,276,815		1,276,815	201.00
202.00		Total (see instructions)	33,240,522	0	33,240,522	7,840	33,248,362	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/28/2024 1:00 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,225,293		2,225,293			30.00
31.00	03100	INTENSIVE CARE UNIT	32,511		32,511			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,784,935	50,103,061	59,887,996	0.143163	0.000000	50.00
51.00	05100	RECOVERY ROOM	731,546	3,689,428	4,420,974	0.066999	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	544,989	9,942,285	10,487,274	0.193788	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	18,326	870,497	888,823	0.002075	0.000000	55.00
56.00	05600	RADIOISOTOPE	47,095	1,220,419	1,267,514	0.177918	0.000000	56.00
57.00	05700	CT SCAN	2,153,290	20,268,087	22,421,377	0.022356	0.000000	57.00
58.00	05800	MRI	84,300	4,233,850	4,318,150	0.080659	0.000000	58.00
60.00	06000	LABORATORY	2,510,212	28,820,876	31,331,088	0.069875	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	235,191	133,893	369,084	0.224800	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	64,048	202,238	266,286	0.000338	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	665,934	524,023	1,189,957	0.588857	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	614,938	4,747,829	5,362,767	0.154479	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	151,711	1,344,544	1,496,255	0.160157	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	27,360	286,683	314,043	0.332827	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	372,115	1,747,208	2,119,323	0.032857	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	244,053	500,725	744,778	0.735727	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,801,799	12,878,929	19,680,728	0.186651	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	475,440	1,554,687	2,030,127	1.039262	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	352,277	53,076	405,353	0.000294	0.000000	76.97
76.99	07699	LITHOTRIPSY	0	627,707	627,707	0.076733	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,328,674	1,328,674			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,269,998	2,269,998			88.01
90.00	09000	CLINIC	0	43,260	43,260	0.000000	0.000000	90.00
90.01	09001	SLEEP SERVICES	0	764,691	764,691	0.284664	0.000000	90.01
91.00	09100	EMERGENCY	1,086,376	14,141,896	15,228,272	0.171623	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	246,564	1,036,810	1,283,374	0.994889	0.000000	92.00
200.00		Subtotal (see instructions)	29,470,303	163,335,374	192,805,677			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	29,470,303	163,335,374	192,805,677			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/28/2024 1:00 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.143163	50.00
51.00	05100	RECOVERY ROOM	0.066999	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194283	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.002075	55.00
56.00	05600	RADIOISOTOPE	0.177918	56.00
57.00	05700	CT SCAN	0.022356	57.00
58.00	05800	MRI	0.080659	58.00
60.00	06000	LABORATORY	0.069875	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.224800	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000338	64.00
65.00	06500	RESPIRATORY THERAPY	0.588857	65.00
66.00	06600	PHYSICAL THERAPY	0.154479	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.160157	67.00
68.00	06800	SPEECH PATHOLOGY	0.332827	68.00
69.00	06900	ELECTROCARDIOLOGY	0.032857	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.735727	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.186651	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.039262	73.00
76.97	07697	CARDIAC REHABILITATION	0.000294	76.97
76.99	07699	LITHOTRIPSY	0.076733	76.99
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	SLEEP SERVICES	0.287714	90.01
91.00	09100	EMERGENCY	0.171644	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.994889	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/28/2024 1:00 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,273,778		4,273,778	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	388,839		388,839	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,573,748		8,573,748	0	0	50.00
51.00	05100	RECOVERY ROOM	296,201		296,201	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,032,311		2,032,311	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,844		1,844	0	0	55.00
56.00	05600	RADIOISOTOPE	225,513		225,513	0	0	56.00
57.00	05700	CT SCAN	501,250		501,250	0	0	57.00
58.00	05800	MRI	348,299		348,299	0	0	58.00
60.00	06000	LABORATORY	2,189,249		2,189,249	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	82,970		82,970	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	90		90	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	700,714	0	700,714	0	0	65.00
66.00	06600	PHYSICAL THERAPY	828,434	0	828,434	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	239,635	0	239,635	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	104,522	0	104,522	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	69,635		69,635	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	547,953		547,953	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,673,422		3,673,422	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,109,834		2,109,834	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	119		119	0	0	76.97
76.99	07699	LITHOTRIPSY	48,166		48,166	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,078,822		1,078,822	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,093,970		2,093,970	0	0	88.01
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	SLEEP SERVICES	217,680		217,680	0	0	90.01
91.00	09100	EMERGENCY	2,613,524		2,613,524	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Subtotal (see instructions)	33,240,522	0	33,240,522	0	0	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	33,240,522	0	33,240,522	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/28/2024 1:00 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,225,293		2,225,293			30.00
31.00	03100	INTENSIVE CARE UNIT	32,511		32,511			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,784,935	50,103,061	59,887,996	0.143163	0.000000	50.00
51.00	05100	RECOVERY ROOM	731,546	3,689,428	4,420,974	0.066999	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	544,989	9,942,285	10,487,274	0.193788	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	18,326	870,497	888,823	0.002075	0.000000	55.00
56.00	05600	RADIOISOTOPE	47,095	1,220,419	1,267,514	0.177918	0.000000	56.00
57.00	05700	CT SCAN	2,153,290	20,268,087	22,421,377	0.022356	0.000000	57.00
58.00	05800	MRI	84,300	4,233,850	4,318,150	0.080659	0.000000	58.00
60.00	06000	LABORATORY	2,510,212	28,820,876	31,331,088	0.069875	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	235,191	133,893	369,084	0.224800	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	64,048	202,238	266,286	0.000338	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	665,934	524,023	1,189,957	0.588857	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	614,938	4,747,829	5,362,767	0.154479	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	151,711	1,344,544	1,496,255	0.160157	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	27,360	286,683	314,043	0.332827	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	372,115	1,747,208	2,119,323	0.032857	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	244,053	500,725	744,778	0.735727	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,801,799	12,878,929	19,680,728	0.186651	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	475,440	1,554,687	2,030,127	1.039262	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	352,277	53,076	405,353	0.000294	0.000000	76.97
76.99	07699	LITHOTRIPSY	0	627,707	627,707	0.076733	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,328,674	1,328,674	0.811954	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,269,998	2,269,998	0.922455	0.000000	88.01
90.00	09000	CLINIC	0	43,260	43,260	0.000000	0.000000	90.00
90.01	09001	SLEEP SERVICES	0	764,691	764,691	0.284664	0.000000	90.01
91.00	09100	EMERGENCY	1,086,376	14,141,896	15,228,272	0.171623	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	246,564	1,036,810	1,283,374	0.000000	0.000000	92.00
200.00		Subtotal (see instructions)	29,470,303	163,335,374	192,805,677			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	29,470,303	163,335,374	192,805,677			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/28/2024 1:00 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	55.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	88.01
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	SLEEP SERVICES	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part I Date/Time Prepared: 2/28/2024 1:00 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	233,389	0	233,389	1,446	161.40	30.00
31.00	INTENSIVE CARE UNIT	39,075		39,075	11	3,552.27	31.00
200.00	Total (lines 30 through 199)	272,464		272,464	1,457		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	422	68,111				30.00
31.00	INTENSIVE CARE UNIT	2	7,105				31.00
200.00	Total (lines 30 through 199)	424	75,216				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/28/2024 1:00 pm

Title XVIII | Hospital | PPS

		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	205,987	59,887,996	0.003440	2,937,681	10,106	50.00
51.00	05100	RECOVERY ROOM	5,249	4,420,974	0.001187	216,169	257	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	68,799	10,487,274	0.006560	270,224	1,773	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	58	888,823	0.000065	0	0	55.00
56.00	05600	RADIOISOTOPE	4,138	1,267,514	0.003265	42,858	140	56.00
57.00	05700	CT SCAN	8,018	22,421,377	0.000358	897,561	321	57.00
58.00	05800	MRI	2,405	4,318,150	0.000557	27,839	16	58.00
60.00	06000	LABORATORY	41,539	31,331,088	0.001326	1,080,777	1,433	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	1,907	369,084	0.005167	149,226	771	63.00
64.00	06400	INTRAVENOUS THERAPY	14	266,286	0.000053	160	0	64.00
65.00	06500	RESPIRATORY THERAPY	17,850	1,189,957	0.015001	193,948	2,909	65.00
66.00	06600	PHYSICAL THERAPY	8,309	5,362,767	0.001549	323,763	502	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,961	1,496,255	0.001311	85,826	113	67.00
68.00	06800	SPEECH PATHOLOGY	888	314,043	0.002828	15,980	45	68.00
69.00	06900	ELECTROCARDIOLOGY	7,259	2,119,323	0.003425	247,951	849	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,485	744,778	0.004679	144,764	677	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,355	19,680,728	0.001238	3,355,262	4,154	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,948	2,030,127	0.011304	161,113	1,821	73.00
76.97	07697	CARDIAC REHABILITATION	18	405,353	0.000044	0	0	76.97
76.99	07699	LITHOTRIPSY	334	627,707	0.000532	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,209	1,328,674	0.006178	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	16,700	2,269,998	0.007357	0	0	88.01
90.00	09000	CLINIC	0	43,260	0.000000	0	0	90.00
90.01	09001	SLEEP SERVICES	6,694	764,691	0.008754	0	0	90.01
91.00	09100	EMERGENCY	85,362	15,228,272	0.005605	482,475	2,704	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	69,727	1,283,374	0.054331	111,231	6,043	92.00
200.00		Total (lines 50 through 199)	612,213	190,547,873		10,744,808	34,634	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part III Date/Time Prepared: 2/28/2024 1:00 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,446	0.00	422	30.00
31.00	03100	INTENSIVE CARE UNIT		0	11	0.00	2	31.00
200.00		Total (lines 30 through 199)		0	1,457		424	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/28/2024 1:00 pm

Title XVIII | Hospital | PPS

		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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		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
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SLEEP SERVICES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/28/2024 1:00 pm

Title XVIII | Hospital | PPS

		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	59,887,996	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,420,974	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,487,274	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	888,823	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	1,267,514	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	22,421,377	0.000000	57.00
58.00	05800	MRI	0	0	0	4,318,150	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	31,331,088	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	369,084	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	266,286	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,189,957	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,362,767	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,496,255	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	314,043	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,119,323	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	744,778	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,680,728	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,030,127	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	405,353	0.000000	76.97
76.99	07699	LITHOTRIPSY	0	0	0	627,707	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,328,674	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,269,998	0.000000	88.01
90.00	09000	CLINIC	0	0	0	43,260	0.000000	90.00
90.01	09001	SLEEP SERVICES	0	0	0	764,691	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	15,228,272	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,283,374	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	190,547,873		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/28/2024 1:00 pm

Title XVIII | Hospital | PPS

		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	2,937,681	0	10,055,509	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	216,169	0	1,373,993	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	270,224	0	2,513,291	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	197,868	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	42,858	0	428,177	0	56.00
57.00	05700	CT SCAN	0.000000	897,561	0	5,702,115	0	57.00
58.00	05800	MRI	0.000000	27,839	0	1,263,224	0	58.00
60.00	06000	LABORATORY	0.000000	1,080,777	0	2,243,908	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	149,226	0	56,418	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	160	0	28,141	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	193,948	0	97,741	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	323,763	0	46,418	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	85,826	0	15,478	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	15,980	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	247,951	0	947,036	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	144,764	0	15,034	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,355,262	0	2,995,278	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	161,113	0	355,523	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.99	07699	LITHOTRIPSY	0.000000	0	0	214,339	0	76.99
		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
90.00	09000	CLINIC	0.000000	0	0	7,787	0	90.00
90.01	09001	SLEEP SERVICES	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	482,475	0	2,730,972	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	111,231	0	160,362	0	92.00
200.00		Total (lines 50 through 199)		10,744,808	0	31,448,612	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/28/2024 1:00 pm

Title XVIII | Hospital | PPS

		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	0.143163	10,055,509	0	0	1,439,577	50.00
51.00	05100	RECOVERY ROOM	0.066999	1,373,993	0	0	92,056	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.193788	2,513,291	982	0	487,046	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.002075	197,868	0	0	411	55.00
56.00	05600	RADIOISOTOPE	0.177918	428,177	0	0	76,180	56.00
57.00	05700	CT SCAN	0.022356	5,702,115	0	0	127,476	57.00
58.00	05800	MRI	0.080659	1,263,224	0	0	101,890	58.00
60.00	06000	LABORATORY	0.069875	2,243,908	0	0	156,793	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.224800	56,418	0	0	12,683	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000338	28,141	0	0	10	64.00
65.00	06500	RESPIRATORY THERAPY	0.588857	97,741	0	0	57,555	65.00
66.00	06600	PHYSICAL THERAPY	0.154479	46,418	0	0	7,171	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.160157	15,478	0	0	2,479	67.00
68.00	06800	SPEECH PATHOLOGY	0.332827	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.032857	947,036	0	0	31,117	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.735727	15,034	0	0	11,061	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.186651	2,995,278	0	0	559,072	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.039262	355,523	0	0	369,482	73.00
76.97	07697	CARDIAC REHABILITATION	0.000294	0	0	0	0	76.97
76.99	07699	LITHOTRIPSY	0.076733	214,339	0	0	16,447	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	0.000000	7,787	0	0	0	90.00
90.01	09001	SLEEP SERVICES	0.284664	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.171623	2,730,972	0	0	468,698	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.994889	160,362	0	0	159,542	92.00
200.00		Subtotal (see instructions)		31,448,612	982	0	4,176,746	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		31,448,612	982	0	4,176,746	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/28/2024 1:00 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	190	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.99	07699	LITHOTRIPSY	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
90.00	09000	CLINIC	0	0	90.00
90.01	09001	SLEEP SERVICES	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	190	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	190	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part I Date/Time Prepared: 2/28/2024 1:00 pm

Title XIX | Hospital | Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	233,389	0	233,389	1,446	161.40	30.00
31.00	INTENSIVE CARE UNIT	39,075		39,075	11	3,552.27	31.00
200.00	Total (lines 30 through 199)	272,464		272,464	1,457		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	0		30.00
31.00	INTENSIVE CARE UNIT	0	0		31.00
200.00	Total (lines 30 through 199)	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/28/2024 1:00 pm

Title XIX | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	205,987	59,887,996	0.003440	82,284	283	50.00
51.00	05100	RECOVERY ROOM	5,249	4,420,974	0.001187	6,346	8	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	68,799	10,487,274	0.006560	1,843	12	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	58	888,823	0.000065	0	0	55.00
56.00	05600	RADIOISOTOPE	4,138	1,267,514	0.003265	0	0	56.00
57.00	05700	CT SCAN	8,018	22,421,377	0.000358	5,709	2	57.00
58.00	05800	MRI	2,405	4,318,150	0.000557	0	0	58.00
60.00	06000	LABORATORY	41,539	31,331,088	0.001326	8,973	12	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	1,907	369,084	0.005167	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	14	266,286	0.000053	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	17,850	1,189,957	0.015001	398	6	65.00
66.00	06600	PHYSICAL THERAPY	8,309	5,362,767	0.001549	1,959	3	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,961	1,496,255	0.001311	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	888	314,043	0.002828	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,259	2,119,323	0.003425	767	3	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,485	744,778	0.004679	17,103	80	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,355	19,680,728	0.001238	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,948	2,030,127	0.011304	1,997	23	73.00
76.97	07697	CARDIAC REHABILITATION	18	405,353	0.000044	0	0	76.97
76.99	07699	LITHOTRIPSY	334	627,707	0.000532	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,209	1,328,674	0.006178	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	16,700	2,269,998	0.007357	0	0	88.01
90.00	09000	CLINIC	0	43,260	0.000000	0	0	90.00
90.01	09001	SLEEP SERVICES	6,694	764,691	0.008754	0	0	90.01
91.00	09100	EMERGENCY	85,362	15,228,272	0.005605	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,283,374	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	542,486	190,547,873		127,379	432	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part III Date/Time Prepared: 2/28/2024 1:00 pm

Title XIX | Hospital | Cost

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,446	0.00	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	11	0.00	0	31.00
200.00		Total (lines 30 through 199)		0	1,457		0	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/28/2024 1:00 pm

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		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
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SLEEP SERVICES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/28/2024 1:00 pm

Title XIX | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	59,887,996	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,420,974	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,487,274	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	888,823	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	1,267,514	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	22,421,377	0.000000	57.00
58.00	05800	MRI	0	0	0	4,318,150	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	31,331,088	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	369,084	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	266,286	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,189,957	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,362,767	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,496,255	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	314,043	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,119,323	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	744,778	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,680,728	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,030,127	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	405,353	0.000000	76.97
76.99	07699	LITHOTRIPSY	0	0	0	627,707	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,328,674	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,269,998	0.000000	88.01
90.00	09000	CLINIC	0	0	0	43,260	0.000000	90.00
90.01	09001	SLEEP SERVICES	0	0	0	764,691	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	15,228,272	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,283,374	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	190,547,873		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/28/2024 1:00 pm

Title XIX | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	82,284	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	6,346	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,843	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	5,709	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	8,973	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	398	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,959	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	767	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	17,103	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	1,997	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		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
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	SLEEP SERVICES	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		127,379	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/28/2024 1:00 pm

Title XIX | 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	0.143163	0	0	937,755	0	50.00
51.00	05100	RECOVERY ROOM	0.066999	0	0	154,168	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.193788	0	0	123,349	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.002075	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.177918	0	0	15,649	0	56.00
57.00	05700	CT SCAN	0.022356	0	0	340,904	0	57.00
58.00	05800	MRI	0.080659	0	0	72,719	0	58.00
60.00	06000	LABORATORY	0.069875	0	0	389,194	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.224800	0	0	7,325	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000338	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.588857	0	0	7,993	0	65.00
66.00	06600	PHYSICAL THERAPY	0.154479	0	0	145,099	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.160157	0	0	75,478	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.332827	0	0	10,531	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.032857	0	0	39,172	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.735727	0	0	394,087	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.186651	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.039262	0	0	33,142	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000294	0	0	0	0	76.97
76.99	07699	LITHOTRIPSY	0.076733	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	SLEEP SERVICES	0.284664	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.171623	0	0	304,347	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	55,705	0	92.00
200.00		Subtotal (see instructions)		0	0	3,106,617	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	3,106,617	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/28/2024 1:00 pm

Title XIX | 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	0	134,252		50.00
51.00	05100	RECOVERY ROOM	0	10,329		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,904		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	2,784		56.00
57.00	05700	CT SCAN	0	7,621		57.00
58.00	05800	MRI	0	5,865		58.00
60.00	06000	LABORATORY	0	27,195		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	1,647		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	4,707		65.00
66.00	06600	PHYSICAL THERAPY	0	22,415		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,088		67.00
68.00	06800	SPEECH PATHOLOGY	0	3,505		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,287		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	289,940		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,443		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
90.00	09000	CLINIC	0	0		90.00
90.01	09001	SLEEP SERVICES	0	0		90.01
91.00	09100	EMERGENCY	0	52,233		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	634,215		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	634,215		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/28/2024 1:00 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,446	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,446	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,014	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	422	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,273,778	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,273,778	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,273,778	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)	2,955.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,247,259	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,247,259	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/28/2024 1:00 pm

Title XVIII | Hospital | PPS

	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	388,839	11	35,349.00	2	70,698	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,911,671	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	3,229,628	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)	75,216	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	34,634	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	109,850	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,119,778	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	432	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,955.59	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,276,815	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/28/2024 1:00 pm

Title XVIII | Hospital | PPS

	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	233,389	4,273,778	0.054610	1,276,815	69,727	90.00
91.00	Nursing Program cost	0	4,273,778	0.000000	1,276,815	0	91.00
92.00	Allied health cost	0	4,273,778	0.000000	1,276,815	0	92.00
93.00	All other Medical Education	0	4,273,778	0.000000	1,276,815	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/28/2024 1:00 pm

Title XVIII | Hospital | PPS

		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		884,968		30.00
31.00	03100	INTENSIVE CARE UNIT		7,264		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.143163	2,937,681	420,567	50.00
51.00	05100	RECOVERY ROOM	0.066999	216,169	14,483	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194283	270,224	52,500	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.002075	0	0	55.00
56.00	05600	RADIOISOTOPE	0.177918	42,858	7,625	56.00
57.00	05700	CT SCAN	0.022356	897,561	20,066	57.00
58.00	05800	MRI	0.080659	27,839	2,245	58.00
60.00	06000	LABORATORY	0.069875	1,080,777	75,519	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.224800	149,226	33,546	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000338	160	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.588857	193,948	114,208	65.00
66.00	06600	PHYSICAL THERAPY	0.154479	323,763	50,015	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.160157	85,826	13,746	67.00
68.00	06800	SPEECH PATHOLOGY	0.332827	15,980	5,319	68.00
69.00	06900	ELECTROCARDIOLOGY	0.032857	247,951	8,147	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.735727	144,764	106,507	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.186651	3,355,262	626,263	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.039262	161,113	167,439	73.00
76.97	07697	CARDIAC REHABILITATION	0.000294	0	0	76.97
76.99	07699	LITHOTRIPSY	0.076733	0	0	76.99
		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
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	SLEEP SERVICES	0.287714	0	0	90.01
91.00	09100	EMERGENCY	0.171644	482,475	82,814	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.994889	111,231	110,662	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		10,744,808	1,911,671	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)		10,744,808		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/28/2024 1:00 pm

Title XIX | 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		10,104		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.143163	82,284	11,780	50.00
51.00	05100	RECOVERY ROOM	0.066999	6,346	425	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.193788	1,843	357	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.002075	0	0	55.00
56.00	05600	RADIOISOTOPE	0.177918	0	0	56.00
57.00	05700	CT SCAN	0.022356	5,709	128	57.00
58.00	05800	MRI	0.080659	0	0	58.00
60.00	06000	LABORATORY	0.069875	8,973	627	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.224800	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000338	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.588857	398	234	65.00
66.00	06600	PHYSICAL THERAPY	0.154479	1,959	303	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.160157	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.332827	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.032857	767	25	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.735727	17,103	12,583	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.186651	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.039262	1,997	2,075	73.00
76.97	07697	CARDIAC REHABILITATION	0.000294	0	0	76.97
76.99	07699	LITHOTRIPSY	0.076733	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.811954	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.922455	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	SLEEP SERVICES	0.284664	0	0	90.01
91.00	09100	EMERGENCY	0.171623	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		127,379	28,537	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)		127,379		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0294	Period: From 01/14/2023 To 09/30/2023	Worksheet E Part A Date/Time Prepared: 2/28/2024 1:00 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,507,066	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	0	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	171,789	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	2.04
3.00	Managed Care Simulated Payments	476,375	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	45.34	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.82	30.00
31.00	Percentage of Medicaid patient days (see instructions)	20.59	31.00
32.00	Sum of lines 30 and 31	25.41	32.00
33.00	Allowable disproportionate share percentage (see instructions)	10.18	33.00
34.00	Disproportionate share adjustment (see instructions)	38,355	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0294	Period: From 01/14/2023 To 09/30/2023	Worksheet E Part A Date/Time Prepared: 2/28/2024 1:00 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,874,403,459	0	35.00
35.01	Factor 3 (see instructions)	0.000026951	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	185,272	0	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	131,975	0	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	131,975		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	1,849,185		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	2,222,012		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	2,128,805	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	125,093	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	1,269	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	2,255,167	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	2,255,167	61.00
62.00	Deductibles billed to program beneficiaries	196,800	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	9,600	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	6,240	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	9,600	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	2,064,607	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0	70.75
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	-2,824	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	0	70.93
70.94	HRR adjustment amount (see instructions)	-15,234	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E Part A Date/Time Prepared: 2/28/2024 1:00 pm

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		2,046,549	71.00
71.01	Sequestration adjustment (see instructions)		40,931	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		2,116,660	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-111,042	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		39,552	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	279,620		100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	1.0000000000		101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0		102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9899		103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-2,824		104.00
	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 inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/28/2024 1:00 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,507,066	0	1,507,066		1,507,066	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	171,789	0	171,789		171,789	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	476,375	0	476,375	0	476,375	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1018	0.1018	0.1018	0.1018		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	38,355	0	38,355	0	38,355	11.00
11.01	Uncompensated care payments	36.00	131,975	0	131,975	0	131,975	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	1,849,185	0	1,849,185	0	1,849,185	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	2,222,012	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	2,128,805	0	2,128,805	0	2,128,805	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	125,093	0	125,093	0	125,093	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/28/2024 1:00 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	1,269	0	1,269	0	1,269	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	2,255,167	0	2,255,167	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	112,088	0	112,088	0	112,088	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	13,005	0	13,005	0	13,005	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	125,093	0	125,093	0	125,093	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/28/2024 1:00 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,507,066	1,507,066		1,507,066	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	171,789	171,789		171,789	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	476,375	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1018	0.1018	0.1018		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	38,355	38,355	0	38,355	11.00
11.01	Uncompensated care payments	36.00	131,975	131,975	0	131,975	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	1,849,185	1,849,185	0	1,849,185	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	2,222,012	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	2,128,805	2,128,805	0	2,128,805	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	125,093	125,093	0	125,093	16.00
17.00	Special add-on payments for new technologies	54.00	1,269	1,269	0	1,269	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			2,255,167	0	2,255,167	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/28/2024 1:00 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	112,088	112,088	0	112,088	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	13,005	13,005	0	13,005	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	125,093	125,093	0	125,093	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-15,234	-15,234	0	-15,234	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-2,824	-2,824	0	-2,824	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0294	Period: From 01/14/2023 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/28/2024 1:00 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	190	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	4,176,746	2.00
3.00	OPPS or REH payments	2,647,981	3.00
4.00	Outlier payment (see instructions)	17,319	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)	190	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	982	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)	982	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)	982	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	792	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)	190	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)	2,665,300	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	196	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	482,084	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,183,210	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	2,183,210	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,183,210	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)	946	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	615	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	946	36.00
37.00	Subtotal (see instructions)	2,183,825	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,183,825	40.00
40.01	Sequestration adjustment (see instructions)	43,677	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	2,220,847	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)	-80,699	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	281,613	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: 14-0294	Period: From 01/14/2023 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/28/2024 1:00 pm
	Title XVIII	Hospital	PPS

		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: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/28/2024 1:00 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,116,660		2,220,847	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,116,660		2,220,847	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		111,042		80,699	6.02
7.00	Total Medicare program liability (see instructions)		2,005,618		2,140,148	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: 14-0294	Period: From 01/14/2023 To 09/30/2023	Worksheet E-1 Part II Date/Time Prepared: 2/28/2024 1:00 pm
	Title XVIII	Hospital	PPS

			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 | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E-3 Part VII | Date/Time Prepared: 2/28/2024 1:00 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		634,215	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	634,215	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	634,215	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	127,379	3,106,617	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	127,379	3,106,617	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	127,379	3,106,617	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	127,379	2,472,402	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	634,215	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	634,215	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	634,215	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	634,215	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	634,215	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	634,215	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	634,215	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 14-0294	Period: From 01/14/2023 To 09/30/2023	Worksheet E-5 Date/Time Prepared: 2/28/2024 1:00 pm
	Title XVIII		PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR		
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2	0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)	0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)	0	4.00
5.00	The rate used to calculate the time value of money (see instructions)	0.00	5.00
6.00	Time value of money for operating expenses (see instructions)	0	6.00
7.00	Time value of money for capital related expenses (see instructions)	0	7.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet G | Date/Time Prepared: 2/28/2024 1:00 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5,103,403	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	13,768,047	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,809,854	0	0	0	7.00
8.00	Prepaid expenses	446,587	0	0	0	8.00
9.00	Other current assets	208,059	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)	21,335,950	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	92,995	0	0	0	15.00
16.00	Accumulated depreciation	0	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	4,522,098	0	0	0	19.00
20.00	Accumulated depreciation	-519,627	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	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	4,095,466	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	99,620	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	1	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	99,621	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	25,531,037	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,563,074	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,206,655	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	14,437,184	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	22,206,913	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	22,206,913	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	3,324,124				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)	3,324,124	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	25,531,037	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet G-1 | Date/Time Prepared: 2/28/2024 1:00 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		8,724,378		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-5,866,839				2.00
3.00	Total (sum of line 1 and line 2)		2,857,539		0		3.00
4.00	INVESTMENT INCOME	466,526		0		0	4.00
5.00	ROUNDING	1		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		466,527		0		10.00
11.00	Subtotal (line 3 plus line 10)		3,324,066		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)		3,324,066		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	INVESTMENT INCOME		0				4.00
5.00	ROUNDING		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0294 | Period: From 01/14/2023 To 09/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/28/2024 1:00 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,222,854		2,222,854	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,222,854		2,222,854	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	32,511		32,511	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)	32,511		32,511	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,255,365		2,255,365	17.00
18.00	Ancillary services	25,882,000	143,350,010	169,232,010	18.00
19.00	Outpatient services	1,332,941	16,386,689	17,719,630	19.00
20.00	RURAL HEALTH CLINIC	0	1,328,674	1,328,674	20.00
20.01	RURAL HEALTH CLINIC II	0	2,269,998	2,269,998	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	29,470,306	163,335,371	192,805,677	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		41,609,324		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)		41,609,324		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0294	Period: From 01/14/2023 To 09/30/2023	Worksheet G-3 Date/Time Prepared: 2/28/2024 1:00 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	192,805,677	1.00
2.00	Less contractual allowances and discounts on patients' accounts	157,114,342	2.00
3.00	Net patient revenues (line 1 minus line 2)	35,691,335	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	41,609,324	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,917,989	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	37,907	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	11,893	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	49,800	25.00
26.00	Total (line 5 plus line 25)	-5,868,189	26.00
27.00	INVESTMENT INCOME	-1,350	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-1,350	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-5,866,839	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0294	Period: From 01/14/2023 To 09/30/2023	Worksheet L Parts I-III Date/Time Prepared: 2/28/2024 1:00 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	112,088	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	13,005	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	3.94	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	125,093	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294 | Component CCN: 14-8523 | Period: From 01/14/2023 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/28/2024 1:00 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	95,193	7,352	102,545	0	102,545	2.00
3.00	Nurse Practitioner	115,840	8,947	124,787	0	124,787	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	11,854	916	12,770	0	12,770	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	148,713	11,486	160,199	0	160,199	9.00
10.00	Subtotal (sum of lines 1 through 9)	371,600	28,701	400,301	0	400,301	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	19,626	19,626	0	19,626	15.00
16.00	Transportation (Health Care Staff)	0	582	582	0	582	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	20,208	20,208	0	20,208	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	371,600	48,909	420,509	0	420,509	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	57,303	57,303	15,894	73,197	29.00
30.00	Administrative Costs	0	21,306	21,306	100,885	122,191	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	78,609	78,609	116,779	195,388	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	371,600	127,518	499,118	116,779	615,897	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294 | Component CCN: 14-8523 | Period: From 01/14/2023 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/28/2024 1:00 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	102,545		2.00
3.00	Nurse Practitioner	0	124,787		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	12,770		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	160,199		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	400,301		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	19,626		15.00
16.00	Transportation (Health Care Staff)	0	582		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	20,208		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	420,509		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	73,197		29.00
30.00	Administrative Costs	0	122,191		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	195,388		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	615,897		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294 | Component CCN: 14-8605 | Period: From 01/14/2023 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/28/2024 1:00 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	43,486	3,530	47,016	0	47,016	1.00
2.00	Physician Assistant	92,704	7,526	100,230	0	100,230	2.00
3.00	Nurse Practitioner	222,428	18,057	240,485	0	240,485	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	24,345	1,976	26,321	0	26,321	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	387,581	31,465	419,046	0	419,046	9.00
10.00	Subtotal (sum of lines 1 through 9)	770,544	62,554	833,098	0	833,098	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	31,067	31,067	0	31,067	15.00
16.00	Transportation (Health Care Staff)	0	893	893	0	893	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	3,285	3,285	0	3,285	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	35,245	35,245	0	35,245	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	770,544	97,799	868,343	0	868,343	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	95,358	95,358	27,155	122,513	29.00
30.00	Administrative Costs	0	115,173	115,173	61,442	176,615	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	210,531	210,531	88,597	299,128	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	770,544	308,330	1,078,874	88,597	1,167,471	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0294 | Component CCN: 14-8605 | Period: From 01/14/2023 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/28/2024 1:00 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	47,016		1.00
2.00	Physician Assistant	0	100,230		2.00
3.00	Nurse Practitioner	0	240,485		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	26,321		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	419,046		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	833,098		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	31,067		15.00
16.00	Transportation (Health Care Staff)	0	893		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	3,285		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	35,245		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	868,343		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	122,513		29.00
30.00	Administrative Costs	0	176,615		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	299,128		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,167,471		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0294 | Component CCN: 14-8523 | Period: From 01/14/2023 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/28/2024 1:00 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.57	2,483	2,100	1,197		2.00
3.00	Nurse Practitioner	0.54	2,489	2,100	1,134		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.11	4,972		2,331	4,972	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.11	4,972			4,972	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)					420,509	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					420,509	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					195,388	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					462,925	15.00
16.00	Total overhead (sum of lines 14 and 15)					658,313	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					658,313	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					658,313	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,078,822	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0294 | Component CCN: 14-8605 | Period: From 01/14/2023 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/28/2024 1:00 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.51	1,497	4,200	2,142		1.00
2.00	Physician Assistant	0.64	2,289	2,100	1,344		2.00
3.00	Nurse Practitioner	1.50	5,579	2,100	3,150		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.65	9,365		6,636	9,365	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.65	9,365			9,365	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)					868,343	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					868,343	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					299,128	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					926,499	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,225,627	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,225,627	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,225,627	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,093,970	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0294 Component CCN: 14-8523	Period: From 01/14/2023 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/28/2024 1:00 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,078,822	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		7,876	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,070,946	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,972	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)		4,972	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		215.40	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/14/2023 through 09/30/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	139.15	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	139.15	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,369	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	190,496	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	190,496	16.00
16.01	Total program charges (see instructions)(from contractor's records)		302,966	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		15,106	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		9,498	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.)		134,432	16.04
16.05	Total program cost (see instructions)	0	143,930	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		12,958	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		54,980	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		143,930	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		7,481	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		151,411	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS		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)		151,411	26.00
26.01	Sequestration adjustment (see instructions)		3,028	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		140,140	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)		8,243	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: 14-0294 Component CCN: 14-8605	Period: From 01/14/2023 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/28/2024 1:00 pm
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,093,970	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			38,881	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,055,089	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			9,365	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			9,365	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			219.44	7.00
		Calculation of Limit (1)			
		Rate Period N/A	Rate Period 1 (01/14/2023 through 09/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	302.71		8.00
9.00	Rate for Program covered visits (see instructions)	0.00	219.44		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,549		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	559,353		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	559,353		16.00
16.01	Total program charges (see instructions)(from contractor's records)		598,630		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		22,770		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		21,276		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.)		403,558		16.04
16.05	Total program cost (see instructions)	0	424,834		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		33,630		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		108,446		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		424,834		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		34,644		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		459,478		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		459,478		26.00
26.01	Sequestration adjustment (see instructions)		9,190		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		583,867		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)		-133,579		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: 14-0294 | Component CCN: 14-8523 | Period: From 01/14/2023 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/28/2024 1:00 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	400,301	400,301	400,301	400,301	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000909	0.001652	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	364	661	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,166	879	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,530	1,540	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	420,509	420,509	420,509	420,509	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	658,313	658,313	658,313	658,313	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.003638	0.003662	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2,395	2,411	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	3,925	3,951	0	0	10.00
11.00	Total number of injections/infusions (from your records)	11	20	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	356.82	197.55	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	11	18	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	3,925	3,556	0	0	14.00

		COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		7,876
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)		7,481

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0294 | Component CCN: 14-8605 | Period: From 01/14/2023 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/28/2024 1:00 pm

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	833,098	833,098	833,098	833,098	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002470	0.002219	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	2,058	1,849	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	10,325	1,892	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	12,383	3,741	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	868,343	868,343	868,343	868,343	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,225,627	1,225,627	1,225,627	1,225,627	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.014260	0.004308	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	17,477	5,280	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	29,860	9,021	0	0	10.00
11.00	Total number of injections/infusions (from your records)	59	53	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	506.10	170.21	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	55	40	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)	27,836	6,808	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)	38,881	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)	34,644	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0294 Component CCN: 14-8523	Period: From 01/14/2023 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/28/2024 1:00 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		140,140	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)		140,140	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		8,243	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		148,383	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: 14-0294 Component CCN: 14-8605	Period: From 01/14/2023 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/28/2024 1:00 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		583,867	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)		583,867	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		133,579	6.02
7.00	Total Medicare program liability (see instructions)		450,288	7.00

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