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: 14-1303	Period: From 05/01/2022 To 04/30/2023	Worksheet S Parts I-III Date/Time Prepared: 9/19/2023 4:25 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 9/19/2023 Time: 4:25 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 WARNER HOSPITAL AND HEALTH SERVICES (14-1303) for the cost reporting period beginning 05/01/2022 and ending 04/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Paul Skowron		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	Paul Skowron			2
3	Signatory Title	CHIEF EXECUTIVE OFFICER			3
4	Date	09/19/2023 04:25:49 PM			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	171,722	2,022	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		114,844		0	10.00
200.00	TOTAL	0	171,722	116,866	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 9/19/2023 4:25 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 422 WEST WHITE STREET	PO Box:			1.00
2.00	City: CLINTON	State: IL	Zip Code: 61727	County: DEWITT	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	WARNER HOSPITAL AND HEALTH SERVICES	141303	99914	1	03/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SWING BED	14Z303	99914		03/01/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	RURAL HEALTH CENTER	143404	99914		07/03/1995	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
17.20	Hospital-Based (OPT) I									17.20
17.30	Hospital-Based (OOT) I									17.30
17.40	Hospital-Based (OSP) I									17.40
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	05/01/2022	04/30/2023	20.00
21.00	Type of Control (see instructions)	12		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 9/19/2023 4:25 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.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
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.	N			57.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 9/19/2023 4:25 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

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

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

		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: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 9/19/2023 4:25 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: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 9/19/2023 4:25 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)?			N	68.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00		
	Long Term Care Hospital PPS			
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00
	TEFRA Providers			
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00

		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
		1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		0	88.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 9/19/2023 4:25 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.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

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

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

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

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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	124,578	0	0	118.01

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

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

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

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

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					1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	Y	Y	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10
161.20	OUTPATIENT PHYSICAL THERAPY		N	N	N	161.20
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N	161.30
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N	N	161.40
					1.00	
	Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 9/19/2023 4:25 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	08/28/2023	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	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	08/10/2023	Y	08/10/2023	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ANDREW	MCCABE	41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	715-858-6660	AMCCABE@WIPFLI.COM	43.00

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		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CPA		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: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 9/19/2023 4:25 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	15	5,475	7,210.61	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)		15	5,475	7,210.61	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		15	5,475	7,210.61	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		15				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: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 9/19/2023 4:25 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)	119	0	207			1.00
2.00	HMO and other (see instructions)	8	7				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)	119	0	207			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)	119	0	207	0.00	93.95	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00	RURAL HEALTH CLINIC	4,721	0	13,999	0.00	20.48	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	114.43	27.00
28.00	Observation Bed Days		0	238			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: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 9/19/2023 4:25 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	40	0	110	1.00
2.00	HMO and other (see instructions)			2	1		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	40	0	110	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
25.10	CMHC - CORF	0.00					25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1303 | Component CCN: 14-3404 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-8 | Date/Time Prepared: 9/19/2023 4:25 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			422 W WHITE STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CLINTON		IL	61727	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			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		DEWITT				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: 14-1303 | Component CCN: 14-3404 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-8 | Date/Time Prepared: 9/19/2023 4:25 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	09:00	13:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-10 | Date/Time Prepared: 9/19/2023 4:25 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.524483	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,628,207	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	6,882,320	6.00
7.00	Medicaid cost (line 1 times line 6)	3,609,660	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	178,231	99,077	277,308	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	93,479	99,077	192,556	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	9,362	9,362	22.00
23.00	Cost of charity care (line 21 minus line 22)	93,479	89,715	183,194	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,147,269	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	170,425	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	262,193	27.01
28.00	Non-Medicare bad debt expense (see instructions)	885,076	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	555,975	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	739,169	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	739,169	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A | Date/Time Prepared: 9/19/2023 4:25 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		402,678	402,678	31,725	434,403	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		536,071	536,071	18,533	554,604	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,754,131	2,754,131	-169,270	2,584,861	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,361,057	1,955,053	3,316,110	-175,121	3,140,989	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	249,200	816,696	1,065,896	0	1,065,896	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	48,048	48,048	0	48,048	8.00
9.00	00900	HOUSEKEEPING	141,205	31,361	172,566	0	172,566	9.00
10.00	01000	DIETARY	148,632	213,698	362,330	-174,932	187,398	10.00
11.00	01100	CAFETERIA	0	0	0	172,614	172,614	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	116,033	43,458	159,491	0	159,491	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	78,895	421,989	500,884	-390,502	110,382	14.00
15.00	01500	PHARMACY	184,298	778,281	962,579	-298,082	664,497	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	240,253	65,141	305,394	0	305,394	16.00
17.00	01700	SOCIAL SERVICE	0	1,920	1,920	0	1,920	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	259,991	259,991	0	259,991	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	874,018	453,298	1,327,316	-49,836	1,277,480	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	245,599	179,922	425,521	8,727	434,248	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	78	78	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	378,059	546,933	924,992	-26	924,966	54.00
60.00	06000	LABORATORY	468,687	639,942	1,108,629	6,514	1,115,143	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,391	1,391	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	96,808	96,808	64.00
65.00	06500	RESPIRATORY THERAPY	139,424	31,934	171,358	-27,421	143,937	65.00
66.00	06600	PHYSICAL THERAPY	0	535,615	535,615	-8,880	526,735	66.00
69.00	06900	ELECTROCARDIOLOGY	128,683	2,162	130,845	0	130,845	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	410,764	410,764	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	84,208	84,208	0	84,208	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	298,082	298,082	73.00
76.00	03950	CARDIAC REHAB	68,389	2,883	71,272	0	71,272	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,899,400	256,990	2,156,390	130,030	2,286,420	88.00
90.00	09000	CLINIC	0	0	0	5,789	5,789	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	827,549	2,044,911	2,872,460	91,214	2,963,674	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,549,381	13,107,314	20,656,695	-21,801	20,634,894	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	78,967	1,590	80,557	757	81,314	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	28,432	2,218	30,650	21,044	51,694	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
194.00	07950	FOUNDATION	18,172	0	18,172	0	18,172	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	7,674,952	13,111,122	20,786,074	0	20,786,074	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A | Date/Time Prepared: 9/19/2023 4:25 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	434,403		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	554,604		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-653,699	1,931,162		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-42,878	3,098,111		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	1,065,896		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	48,048		8.00
9.00	00900	HOUSEKEEPING	0	172,566		9.00
10.00	01000	DIETARY	-47,551	139,847		10.00
11.00	01100	CAFETERIA	-46,776	125,838		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	159,491		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	110,382		14.00
15.00	01500	PHARMACY	-117,837	546,660		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,630	302,764		16.00
17.00	01700	SOCIAL SERVICE	0	1,920		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	259,991		19.00
20.00	02000	NURSING PROGRAM	0	0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-364,945	912,535		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-110,462	323,786		50.00
53.00	05300	ANESTHESIOLOGY	0	78		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	924,966		54.00
60.00	06000	LABORATORY	0	1,115,143		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,391		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400	INTRAVENOUS THERAPY	0	96,808		64.00
65.00	06500	RESPIRATORY THERAPY	0	143,937		65.00
66.00	06600	PHYSICAL THERAPY	-359	526,376		66.00
69.00	06900	ELECTROCARDIOLOGY	-21,048	109,797		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	410,764		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	84,208		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-6,228	291,854		73.00
76.00	03950	CARDIAC REHAB	0	71,272		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	2,286,420		88.00
90.00	09000	CLINIC	0	5,789		90.00
90.01	09001	PROVIDER BASED CLINIC	0	0		90.01
91.00	09100	EMERGENCY	-346	2,963,328		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0		99.40
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,414,759	19,220,135		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	81,314		192.00
192.01	19201	LIFELINE	0	0		192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0		192.02
192.03	19203	COMMUNITY BENEFIT	0	51,694		192.03
192.04	19204	RENTAL PROPERTIES	0	0		192.04
194.00	07950	FOUNDATION	0	18,172		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,414,759	19,371,315		200.00

RECLASSIFICATIONS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-6 | Date/Time Prepared: 9/19/2023 4:25 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS CAFETERIA COSTS FROM DIET					
1.00	CAFETERIA	11.00	70,808	101,806		1.00
2.00	EMERGENCY	91.00	490	705		2.00
3.00	OPERATING ROOM	50.00	461	662		3.00
	TOTALS		71,759	103,173		
	B - TO RECLASS DRUGS SOLD TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	298,082		1.00
	TOTALS		0	298,082		
	D - TO RECLASS SUPPLIES CHARGED TO PTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	383,343		1.00
	TOTALS		0	383,343		
	F - TO RECLSS PROPERTY INS EXP					
1.00	OTHER CAP REL COSTS	3.00	0	51,015		1.00
	TOTALS		0	51,015		
	G - TO RECLASS RHC ADMIN EXPENSES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	37,715		1.00
	TOTALS		0	37,715		
	H - TO RECLASS OXYGEN SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	27,421		1.00
	TOTALS		0	27,421		
	I - TO RECLASS NURSING COST					
1.00	INTRAVENOUS THERAPY	64.00	96,808	0		1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	1,391	0		2.00
3.00	CLINIC	90.00	5,789	0		3.00
4.00	EMERGENCY	91.00	4,085	0		4.00
5.00	OPERATING ROOM	50.00	104	0		5.00
6.00	ANESTHESIOLOGY	53.00	78	0		6.00
	TOTALS		108,255	0		
	J - TO RECLASS GRANT EXPENSES					
1.00	RURAL HEALTH CLINIC	88.00	0	29,321		1.00
2.00	EMERGENCY	91.00	0	126,117		2.00
3.00	OPERATING ROOM	50.00	0	7,500		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	16,686		4.00
5.00	COMMUNITY BENEFIT	192.03	0	6,249		5.00
	TOTALS		0	185,873		
	K - TO RECLASS RHC PHYSICIAN TIME					
1.00	ADULTS & PEDIATRICS	30.00	1,228	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	19,808	0		2.00
	TOTALS		21,036	0		
	L - TO RECLASS ATHLETIC TRAINER COM BEN					
1.00	COMMUNITY BENEFIT	192.03	0	14,795		1.00
	TOTALS		0	14,795		
	N - TO RECLASS RHC LAB TESTS					
1.00	LABORATORY	60.00	6,514	0		1.00
	TOTALS		6,514	0		
	O - TO RECLASS RESTRICTED DONATIONS					
1.00	PHYSICAL THERAPY	66.00	0	5,915		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	182		2.00
	TOTALS		0	6,097		
	P - OP CLINIC MME DEPRECIATION					
1.00	PHYSICIANS PRIVATE OFFICES	192.00	0	757		1.00
	TOTALS		0	757		
	Q - DIRECT ASSIGN RHC PHYSICIAN BENEFITS					
1.00	RURAL HEALTH CLINIC	88.00	0	165,974		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	114		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	3,182		3.00
	TOTALS		0	169,270		
	R - CELLPHONE EXPENSES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,159		1.00
	TOTALS		0	7,159		
500.00	Grand Total: Increases		207,564	1,284,700		500.00

RECLASSIFICATIONS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-6 | Date/Time Prepared: 9/19/2023 4:25 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS CAFETERIA COSTS FROM DIET						
1.00	DIETARY	10.00	71,759	103,173	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		71,759	103,173			
	B - TO RECLASS DRUGS SOLD TO PATIENTS						
1.00	PHARMACY	15.00	0	298,082	0		1.00
	TOTALS		0	298,082			
	D - TO RECLASS SUPPLIES CHARGED TO PTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	383,343	0		1.00
	TOTALS		0	383,343			
	F - TO RECLSS PROPERTY INS EXP						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	51,015	12		1.00
	TOTALS		0	51,015			
	G - TO RECLASS RHC ADMIN EXPENSES						
1.00	RURAL HEALTH CLINIC	88.00	0	37,715	0		1.00
	TOTALS		0	37,715			
	H - TO RECLASS OXYGEN SUPPLIES						
1.00	RESPIRATORY THERAPY	65.00	0	27,421	0		1.00
	TOTALS		0	27,421			
	I - TO RECLASS NURSING COST						
1.00	ADULTS & PEDIATRICS	30.00	68,046	0	0		1.00
2.00	EMERGENCY	91.00	40,183	0	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	26	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
	TOTALS		108,255	0			
	J - TO RECLASS GRANT EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	185,873	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
	TOTALS		0	185,873			
	K - TO RECLASS RHC PHYSICIAN TIME						
1.00	RURAL HEALTH CLINIC	88.00	21,036	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		21,036	0			
	L - TO RECLASS ATHLETIC TRAINER COM BEN						
1.00	PHYSICAL THERAPY	66.00	0	14,795	0		1.00
	TOTALS		0	14,795			
	N - TO RECLASS RHC LAB TESTS						
1.00	RURAL HEALTH CLINIC	88.00	6,514	0	0		1.00
	TOTALS		6,514	0			
	O - TO RECLASS RESTRICTED DONATIONS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,097	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	6,097			
	P - OP CLINIC MME DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	757	9		1.00
	TOTALS		0	757			
	Q - DIRECT ASSIGN RHC PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	169,270	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	169,270			
	R - CELLPHONE EXPENSES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,159	0		1.00
	TOTALS		0	7,159			
500.00	Grand Total: Decreases		207,564	1,284,700			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 9/19/2023 4:25 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	545,502	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	12,673,755	163,918	0	163,918	22,507	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	267,323	303,271	0	303,271	11,864	5.00
6.00	Movable Equipment	6,218,268	379,578	0	379,578	372,069	6.00
7.00	HIT designated Assets	1,007,286	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,712,134	846,767	0	846,767	406,440	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	20,712,134	846,767	0	846,767	406,440	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	545,502	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	12,815,166	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	558,730	0	5.00
6.00	Movable Equipment	6,225,777	0	6.00
7.00	HIT designated Assets	1,007,286	0	7.00
8.00	Subtotal (sum of lines 1-7)	21,152,461	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	21,152,461	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-7 Part II Date/Time Prepared: 9/19/2023 4:25 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	402,678	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	536,071	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	938,749	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	402,678		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	536,071		2.00
3.00	Total (sum of lines 1-2)	0	938,749		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 9/19/2023 4:25 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	12,815,167	0	12,815,167	0.621885	31,725	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,791,792	0	7,791,792	0.378115	19,290	2.00
3.00	Total (sum of lines 1-2)	20,606,959	0	20,606,959	1.000000	51,015	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	31,725	402,678	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	19,290	535,314	0	2.00
3.00	Total (sum of lines 1-2)	0	0	51,015	937,992	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	31,725	0	0	434,403	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	19,290	0	0	554,604	2.00
3.00	Total (sum of lines 1-2)	0	51,015	0	0	989,007	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-8 | Date/Time Prepared: 9/19/2023 4:25 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)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-747	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-496,455			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	72,262			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-46,776	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	0	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-6,228	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,630	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	-861	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-8 | Date/Time Prepared: 9/19/2023 4:25 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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER INCOME	B	-6,280	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	OUTSIDE DIETARY SERVICES	B	-46,690	DIETARY	10.00	0	34.00
35.00	RESTING METABOLIC INCOME	B	0	RESPIRATORY THERAPY	65.00	0	35.00
36.00	FITNESS MGMT	B	-300	PHYSICAL THERAPY	66.00	0	36.00
37.00	NON-ALLOW AMORTIZATION	A	0	RURAL HEALTH CLINIC	88.00	0	37.00
38.00	EHR DEPRECIATION - CAPITAL LEAS	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	38.00
39.00	OTHER REVENUE - RHC	B	0	RURAL HEALTH CLINIC	88.00	0	39.00
40.00	PEACE MEAL STAFF TIME/OTHER COMM BEN	A	-10,110	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	LOBBYING EXPENSE	A	-8,360	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	ADVERTISING AND MARKETING	A	-80,900	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	NON-ALLOWABLE PT MARKETING/OTHER CST	A	-59	PHYSICAL THERAPY	66.00	0	43.00
44.00	CLINICAL TRAINING CLASSES	B	0	NURSING ADMINISTRATION	13.00	0	44.00
45.00	PENSION DIFFERENTIAL	A	-653,699	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.00
46.00	340B PROGRAM EXPENSES	A	-117,837	PHARMACY	15.00	0	46.00
47.00	OTHER REVENUE - CARDIAC REHAB	B	0	CARDIAC REHAB	76.00	0	47.00
48.00	NON-ALLOWABLE CONTRIBUTIONS	A	-3,452	ADMINISTRATIVE & GENERAL	5.00	0	48.00
49.00	INTEREST FROM INSURANCE COMPANIES	B	-5,291	ADMINISTRATIVE & GENERAL	5.00	0	49.00
49.01	ER OUTSIDE SUPPLIES	A	-346	EMERGENCY	91.00	0	49.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,414,759				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: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 9/19/2023 4:25 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	ADMINISTRATION & GENERAL	72,262	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			72,262	0	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B		0.00	CITY OF CLINTON	0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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.

(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: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 9/19/2023 4:25 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	72,262	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	72,262			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	CITY GOVERNMENT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 9/19/2023 4:25 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	60.00	LABORATORY	1,738	0	1,738	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	21,048	21,048	0	0	0	2.00
3.00	50.00	OPERATING ROOM	110,462	110,462	0	0	0	3.00
4.00	91.00	EMERGENCY	1,494,923	0	1,494,923	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	364,945	364,945	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,993,116	496,455	1,496,661		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	0		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	21,048		2.00
3.00	50.00	OPERATING ROOM	0	0	0	110,462		3.00
4.00	91.00	EMERGENCY	0	0	0	0		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	364,945		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	496,455		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1303	Period: From 05/01/2022 To 04/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/19/2023 4:25 pm

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					240	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.55	7.00
8.00	Optional travel expense rate per mile					0.54	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	3,433.00	2,719.00	710.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	84.93	60.89	13.78	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	42.47	42.47	30.45			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					291,565	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					165,560	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					457,125	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					9,784	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					466,909	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					466,909	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					10,193	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					10,193	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,332	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					11,525	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					11,525	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 9/19/2023 4:25 pm

Physical Therapy | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	84.93	60.89	13.78	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	466,909		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	11,525		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	478,434		63.00
64.00	Total cost of outside supplier services (from your records)	240,353		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	10,193		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,332		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	11,525		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,332		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	1,332		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part I Date/Time Prepared: 9/19/2023 4:25 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	434,403	434,403				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	554,604		554,604			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,931,162	0	0	1,931,162		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,098,111	78,506	104,425	402,143	3,683,185	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,065,896	63,233	84,109	73,629	1,286,867	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	48,048	6,179	8,218	0	62,445	8.00
9.00	00900	HOUSEKEEPING	172,566	2,200	2,926	41,721	219,413	9.00
10.00	01000	DIETARY	139,847	15,258	20,296	22,713	198,114	10.00
11.00	01100	CAFETERIA	125,838	0	0	20,921	146,759	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	159,491	2,089	2,779	34,283	198,642	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	110,382	12,040	16,015	23,310	161,747	14.00
15.00	01500	PHARMACY	546,660	4,562	6,068	54,453	611,743	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	302,764	14,291	19,009	70,986	407,050	16.00
17.00	01700	SOCIAL SERVICE	1,920	0	0	0	1,920	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	259,991	0	0	0	259,991	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	912,535	31,587	42,015	238,134	1,224,271	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	323,786	39,626	52,708	72,732	488,852	50.00
53.00	05300	ANESTHESIOLOGY	78	0	0	23	101	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	924,966	15,908	21,160	111,694	1,073,728	54.00
60.00	06000	LABORATORY	1,115,143	10,564	14,051	140,404	1,280,162	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,391	0	0	411	1,802	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	96,808	2,303	3,064	28,603	130,778	64.00
65.00	06500	RESPIRATORY THERAPY	143,937	2,783	3,702	41,194	191,616	65.00
66.00	06600	PHYSICAL THERAPY	526,376	17,584	23,389	0	567,349	66.00
69.00	06900	ELECTROCARDIOLOGY	109,797	2,008	2,671	38,021	152,497	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	410,764	0	0	0	410,764	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	84,208	0	0	0	84,208	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	291,854	0	0	0	291,854	73.00
76.00	03950	CARDIAC REHAB	71,272	3,979	5,292	20,206	100,749	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,286,420	67,515	89,804	222,781	2,666,520	88.00
90.00	09000	CLINIC	5,789	0	0	1,710	7,499	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	2,963,328	24,737	32,903	233,988	3,254,956	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,220,135	416,952	554,604	1,894,060	19,165,582	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	81,314	17,451	0	23,332	122,097	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	51,694	0	0	8,401	60,095	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
194.00	07950	FOUNDATION	18,172	0	0	5,369	23,541	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,371,315	434,403	554,604	1,931,162	19,371,315	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part I | Date/Time Prepared: 9/19/2023 4:25 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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	3,683,185					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	302,124	0	1,588,991			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14,661	0	33,547	110,653		8.00
9.00	00900	HOUSEKEEPING	51,513	0	11,944	0	282,870	9.00
10.00	01000	DIETARY	46,512	0	82,844	0	15,182	10.00
11.00	01100	CAFETERIA	34,455	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	46,636	0	11,342	0	2,079	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	37,974	0	65,370	0	11,980	14.00
15.00	01500	PHARMACY	143,622	0	24,769	0	4,539	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	95,565	0	77,594	0	14,220	16.00
17.00	01700	SOCIAL SERVICE	451	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	61,039	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	287,428	0	171,500	110,653	31,430	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	114,770	0	215,147	0	39,429	50.00
53.00	05300	ANESTHESIOLOGY	24	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	252,084	0	86,371	0	15,829	54.00
60.00	06000	LABORATORY	300,550	0	57,354	0	10,511	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	423	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	30,703	0	12,505	0	2,292	64.00
65.00	06500	RESPIRATORY THERAPY	44,987	0	15,110	0	2,769	65.00
66.00	06600	PHYSICAL THERAPY	133,199	0	95,469	0	17,496	66.00
69.00	06900	ELECTROCARDIOLOGY	35,802	0	10,902	0	1,998	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	96,437	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,770	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,520	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	23,653	0	21,603	0	3,959	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	626,032	0	366,566	0	67,179	88.00
90.00	09000	CLINIC	1,761	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	764,189	0	134,306	0	24,614	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,634,884	0	1,494,243	110,653	265,506	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	28,665	0	94,748	0	17,364	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	14,109	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
194.00	07950	FOUNDATION	5,527	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,683,185	0	1,588,991	110,653	282,870	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part I | Date/Time Prepared: 9/19/2023 4:25 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	342,652					10.00
11.00	01100	CAFETERIA	0	181,214				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	3,653	0	262,352		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,484	0	0	279,555	14.00
15.00	01500	PHARMACY	0	5,802	0	0	1,009	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,564	0	0	53	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	583	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	342,652	25,413	0	91,937	10,348	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,750	0	25,346	13,455	50.00
53.00	05300	ANESTHESIOLOGY	0	2	0	8	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,902	0	0	11,511	54.00
60.00	06000	LABORATORY	0	14,961	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	44	0	144	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	3,048	0	10,054	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,389	0	0	1,199	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	886	66.00
69.00	06900	ELECTROCARDIOLOGY	0	4,051	0	0	813	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	168,067	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	36,919	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	2,153	0	7,081	986	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	58,930	0	37,704	5,896	88.00
90.00	09000	CLINIC	0	182	0	601	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	24,933	0	81,307	27,723	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	342,652	177,261	0	254,182	279,448	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	2,486	0	8,170	107	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	895	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
194.00	07950	FOUNDATION	0	572	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	342,652	181,214	0	262,352	279,555	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part I | Date/Time Prepared: 9/19/2023 4:25 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	791,484					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	602,046				16.00
17.00	01700	SOCIAL SERVICE	0	0	2,371			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	321,613		19.00
20.00	02000	NURSING PROGRAM	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	10,905	2,371	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	28,425	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	16,222	0	321,613	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	152,847	0	0	0	54.00
60.00	06000	LABORATORY	0	115,951	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	502	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	27,011	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,372	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	63,762	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	11,629	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,231	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,398	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	657,917	25,248	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	2,635	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	133,567	56,909	0	0	0	88.00
90.00	09000	CLINIC	0	966	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	67,033	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	791,484	602,046	2,371	321,613	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	791,484	602,046	2,371	321,613	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part I | Date/Time Prepared: 9/19/2023 4:25 pm

		Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	2,308,908	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	933,174	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	337,970	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,604,272	0	54.00
60.00	06000	LABORATORY	0	0	0	1,779,489	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2,915	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	216,391	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	264,442	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	878,161	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	217,692	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	690,499	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	143,295	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,043,539	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	162,819	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,019,303	0	88.00
90.00	09000	CLINIC	0	0	0	11,009	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	4,379,061	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	18,992,939	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	273,637	0	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	75,099	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
194.00	07950	FOUNDATION	0	0	0	29,640	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	19,371,315	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part I | Date/Time Prepared: 9/19/2023 4:25 pm

		Cost Center Description	Total		
			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
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING PROGRAM			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,308,908		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	933,174		50.00
53.00	05300	ANESTHESIOLOGY	337,970		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,604,272		54.00
60.00	06000	LABORATORY	1,779,489		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,915		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
64.00	06400	INTRAVENOUS THERAPY	216,391		64.00
65.00	06500	RESPIRATORY THERAPY	264,442		65.00
66.00	06600	PHYSICAL THERAPY	878,161		66.00
69.00	06900	ELECTROCARDIOLOGY	217,692		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	690,499		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	143,295		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,043,539		73.00
76.00	03950	CARDIAC REHAB	162,819		76.00
76.97	07697	CARDIAC REHABILITATION	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		76.98
76.99	07699	LITHOTRIPSY	0		76.99
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	4,019,303		88.00
90.00	09000	CLINIC	11,009		90.00
90.01	09001	PROVIDER BASED CLINIC	0		90.01
91.00	09100	EMERGENCY	4,379,061		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		99.40
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,992,939		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS PRIVATE OFFICES	273,637		192.00
192.01	19201	LIFELINE	0		192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0		192.02
192.03	19203	COMMUNITY BENEFIT	75,099		192.03
192.04	19204	RENTAL PROPERTIES	0		192.04
194.00	07950	FOUNDATION	29,640		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	19,371,315		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part II Date/Time Prepared: 9/19/2023 4:25 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	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	78,506	104,425	182,931	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	63,233	84,109	147,342	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,179	8,218	14,397	0	8.00
9.00	00900	HOUSEKEEPING	0	2,200	2,926	5,126	0	9.00
10.00	01000	DIETARY	0	15,258	20,296	35,554	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	2,089	2,779	4,868	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,040	16,015	28,055	0	14.00
15.00	01500	PHARMACY	0	4,562	6,068	10,630	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,291	19,009	33,300	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	31,587	42,015	73,602	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	39,626	52,708	92,334	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,908	21,160	37,068	0	54.00
60.00	06000	LABORATORY	0	10,564	14,051	24,615	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	2,303	3,064	5,367	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,783	3,702	6,485	0	65.00
66.00	06600	PHYSICAL THERAPY	0	17,584	23,389	40,973	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,008	2,671	4,679	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
76.00	03950	CARDIAC REHAB	0	3,979	5,292	9,271	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	67,515	89,804	157,319	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	24,737	32,903	57,640	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	416,952	554,604	971,556	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	17,451	0	17,451	0	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	434,403	554,604	989,007	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part II | Date/Time Prepared: 9/19/2023 4:25 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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	182,931					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	15,005	0	162,347			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	728	0	3,427	18,552		8.00
9.00	00900	HOUSEKEEPING	2,558	0	1,220	0	8,904	9.00
10.00	01000	DIETARY	2,310	0	8,464	0	478	10.00
11.00	01100	CAFETERIA	1,711	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,316	0	1,159	0	65	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,886	0	6,679	0	377	14.00
15.00	01500	PHARMACY	7,133	0	2,531	0	143	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,746	0	7,928	0	448	16.00
17.00	01700	SOCIAL SERVICE	22	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	3,031	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,275	0	17,522	18,552	989	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,700	0	21,982	0	1,241	50.00
53.00	05300	ANESTHESIOLOGY	1	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,520	0	8,825	0	498	54.00
60.00	06000	LABORATORY	14,927	0	5,860	0	331	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	21	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	1,525	0	1,278	0	72	64.00
65.00	06500	RESPIRATORY THERAPY	2,234	0	1,544	0	87	65.00
66.00	06600	PHYSICAL THERAPY	6,615	0	9,754	0	551	66.00
69.00	06900	ELECTROCARDIOLOGY	1,778	0	1,114	0	63	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,790	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	982	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,403	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	1,175	0	2,207	0	125	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	31,092	0	37,451	0	2,114	88.00
90.00	09000	CLINIC	87	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	37,961	0	13,722	0	775	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	180,532	0	152,667	18,552	8,357	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,424	0	9,680	0	547	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	701	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
194.00	07950	FOUNDATION	274	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	182,931	0	162,347	18,552	8,904	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part II | Date/Time Prepared: 9/19/2023 4:25 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	46,806					10.00
11.00	01100	CAFETERIA	0	1,711				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	34	0	8,442		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	23	0	0	37,020	14.00
15.00	01500	PHARMACY	0	55	0	0	134	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	71	0	0	7	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	77	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,806	240	0	2,957	1,370	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	73	0	816	1,782	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	112	0	0	1,524	54.00
60.00	06000	LABORATORY	0	141	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	5	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	29	0	324	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	41	0	0	159	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	117	66.00
69.00	06900	ELECTROCARDIOLOGY	0	38	0	0	108	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	22,256	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,889	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	20	0	228	131	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	561	0	1,213	781	88.00
90.00	09000	CLINIC	0	2	0	19	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	235	0	2,617	3,671	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,806	1,675	0	8,179	37,006	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	23	0	263	14	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	8	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
194.00	07950	FOUNDATION	0	5	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	46,806	1,711	0	8,442	37,020	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part II | Date/Time Prepared: 9/19/2023 4:25 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	20,626					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	46,500				16.00
17.00	01700	SOCIAL SERVICE	0	0	22			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	3,108		19.00
20.00	02000	NURSING PROGRAM	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	842	22			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,195	0			50.00
53.00	05300	ANESTHESIOLOGY	0	1,253	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,807	0			54.00
60.00	06000	LABORATORY	0	8,955	0			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	39	0			62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
64.00	06400	INTRAVENOUS THERAPY	0	2,086	0			64.00
65.00	06500	RESPIRATORY THERAPY	0	338	0			65.00
66.00	06600	PHYSICAL THERAPY	0	4,925	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	898	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,176	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	185	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,145	1,950	0			73.00
76.00	03950	CARDIAC REHAB	0	204	0			76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,481	4,395	0			88.00
90.00	09000	CLINIC	0	75	0			90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0			90.01
91.00	09100	EMERGENCY	0	5,177	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,626	46,500	22	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0			192.00
192.01	19201	LIFELINE	0	0	0			192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0			192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0			192.03
192.04	19204	RENTAL PROPERTIES	0	0	0			192.04
194.00	07950	FOUNDATION	0	0	0			194.00
200.00		Cross Foot Adjustments				3,108	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	20,626	46,500	22	3,108	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part II Date/Time Prepared: 9/19/2023 4:25 pm

		Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				177,177	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM				126,123	0	50.00
53.00	05300	ANESTHESIOLOGY				1,254	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				72,354	0	54.00
60.00	06000	LABORATORY				54,829	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL				65	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
64.00	06400	INTRAVENOUS THERAPY				10,681	0	64.00
65.00	06500	RESPIRATORY THERAPY				10,888	0	65.00
66.00	06600	PHYSICAL THERAPY				62,935	0	66.00
69.00	06900	ELECTROCARDIOLOGY				8,678	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				28,222	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				6,056	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				22,498	0	73.00
76.00	03950	CARDIAC REHAB				13,361	0	76.00
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				238,407	0	88.00
90.00	09000	CLINIC				183	0	90.00
90.01	09001	PROVIDER BASED CLINIC				0	0	90.01
91.00	09100	EMERGENCY				121,798	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	955,509	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES				29,402	0	192.00
192.01	19201	LIFELINE				0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT				0	0	192.02
192.03	19203	COMMUNITY BENEFIT				709	0	192.03
192.04	19204	RENTAL PROPERTIES				0	0	192.04
194.00	07950	FOUNDATION				279	0	194.00
200.00		Cross Foot Adjustments	0	0	0	3,108	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	989,007	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part II Date/Time Prepared: 9/19/2023 4:25 pm

		Cost Center Description	Total		
			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
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING PROGRAM			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	177,177		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	126,123		50.00
53.00	05300	ANESTHESIOLOGY	1,254		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,354		54.00
60.00	06000	LABORATORY	54,829		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	65		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
64.00	06400	INTRAVENOUS THERAPY	10,681		64.00
65.00	06500	RESPIRATORY THERAPY	10,888		65.00
66.00	06600	PHYSICAL THERAPY	62,935		66.00
69.00	06900	ELECTROCARDIOLOGY	8,678		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,222		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,056		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,498		73.00
76.00	03950	CARDIAC REHAB	13,361		76.00
76.97	07697	CARDIAC REHABILITATION	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		76.98
76.99	07699	LITHOTRIPSY	0		76.99
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	238,407		88.00
90.00	09000	CLINIC	183		90.00
90.01	09001	PROVIDER BASED CLINIC	0		90.01
91.00	09100	EMERGENCY	121,798		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		99.40
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	955,509		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS PRIVATE OFFICES	29,402		192.00
192.01	19201	LIFELINE	0		192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0		192.02
192.03	19203	COMMUNITY BENEFIT	709		192.03
192.04	19204	RENTAL PROPERTIES	0		192.04
194.00	07950	FOUNDATION	279		194.00
200.00		Cross Foot Adjustments	3,108		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	989,007		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/19/2023 4:25 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	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	58,847					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		56,483				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	6,536,076			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,635	10,635	1,361,057	-3,683,185	15,688,130	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	8,566	8,566	249,200	0	1,286,867	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	837	837	0	0	62,445	8.00
9.00	00900	HOUSEKEEPING	298	298	141,205	0	219,413	9.00
10.00	01000	DIETARY	2,067	2,067	76,873	0	198,114	10.00
11.00	01100	CAFETERIA	0	0	70,808	0	146,759	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	283	283	116,033	0	198,642	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,631	1,631	78,895	0	161,747	14.00
15.00	01500	PHARMACY	618	618	184,298	0	611,743	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,936	1,936	240,253	0	407,050	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	1,920	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	259,991	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,279	4,279	805,972	0	1,224,271	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,368	5,368	246,164	0	488,852	50.00
53.00	05300	ANESTHESIOLOGY	0	0	78	0	101	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,155	2,155	378,033	0	1,073,728	54.00
60.00	06000	LABORATORY	1,431	1,431	475,201	0	1,280,162	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	1,391	0	1,802	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	312	312	96,808	0	130,778	64.00
65.00	06500	RESPIRATORY THERAPY	377	377	139,424	0	191,616	65.00
66.00	06600	PHYSICAL THERAPY	2,382	2,382	0	0	567,349	66.00
69.00	06900	ELECTROCARDIOLOGY	272	272	128,683	0	152,497	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	410,764	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	84,208	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	291,854	73.00
76.00	03950	CARDIAC REHAB	539	539	68,389	0	100,749	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,146	9,146	754,010	0	2,666,520	88.00
90.00	09000	CLINIC	0	0	5,789	0	7,499	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	3,351	3,351	791,941	0	3,254,956	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,483	56,483	6,410,505	-3,683,185	15,482,397	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,364	0	78,967	0	122,097	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	28,432	0	60,095	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
194.00	07950	FOUNDATION	0	0	18,172	0	23,541	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	434,403	554,604	1,931,162		3,683,185	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.381906	9.818954	0.295462		0.234775	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/19/2023 4:25 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			0		182,931	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.011660	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: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/19/2023 4:25 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	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						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	39,646				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	837	445			8.00
9.00	00900	HOUSEKEEPING	0	298	0	38,511		9.00
10.00	01000	DIETARY	0	2,067	0	2,067	445	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	283	0	283	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,631	0	1,631	0	14.00
15.00	01500	PHARMACY	0	618	0	618	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,936	0	1,936	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,279	445	4,279	445	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,368	0	5,368	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,155	0	2,155	0	54.00
60.00	06000	LABORATORY	0	1,431	0	1,431	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	312	0	312	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	377	0	377	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,382	0	2,382	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	272	0	272	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
76.00	03950	CARDIAC REHAB	0	539	0	539	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	9,146	0	9,146	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	3,351	0	3,351	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	37,282	445	36,147	445	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	2,364	0	2,364	0	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,588,991	110,653	282,870	342,652	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	40.079478	248.658427	7.345174	770.004494	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	162,347	18,552	8,904	46,806	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	4.094915	41.689888	0.231207	105.182022	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/19/2023 4:25 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
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: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/19/2023 4:25 pm

		Cost Center Description	CAFETERIA (GROSS SALARIES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSG SALARY)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	5,756,001					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	116,033	0	2,526,211			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	78,895	0	0	637,633		14.00
15.00	01500	PHARMACY	184,298	0	0	2,301	358,596	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	240,253	0	0	121	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	1,329	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	807,200	0	885,262	23,603	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	246,164	0	244,057	30,690	0	50.00
53.00	05300	ANESTHESIOLOGY	78	0	78	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	378,033	0	0	26,256	0	54.00
60.00	06000	LABORATORY	475,201	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,391	0	1,391	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	96,808	0	96,808	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	139,424	0	0	2,735	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,020	0	66.00
69.00	06900	ELECTROCARDIOLOGY	128,683	0	0	1,854	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	383,343	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	84,208	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	298,081	73.00
76.00	03950	CARDIAC REHAB	68,389	0	68,187	2,248	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,871,850	0	363,058	13,448	60,515	88.00
90.00	09000	CLINIC	5,789	0	5,789	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	791,941	0	782,915	63,234	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,630,430	0	2,447,545	637,390	358,596	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	78,967	0	78,666	243	0	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	28,432	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
194.00	07950	FOUNDATION	18,172	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	181,214	0	262,352	279,555	791,484	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.031483	0.000000	0.103852	0.438426	2.207175	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,711	0	8,442	37,020	20,626	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/19/2023 4:25 pm

		Cost Center Description	CAFETERIA (GROSS SALARIES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSG SALARY)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000297	0.000000	0.003342	0.058058	0.057519	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: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/19/2023 4:25 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	36,212,680					16.00
17.00	01700	SOCIAL SERVICE	0	445				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	100			19.00
20.00	02000	NURSING PROGRAM	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	655,936	445	0	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,709,784	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	975,783	0	100	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,193,111	0	0	0	0	54.00
60.00	06000	LABORATORY	6,974,525	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	30,208	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	1,624,702	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	262,966	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,835,316	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	699,484	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	916,170	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	144,252	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,518,677	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	158,517	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,423,068	0	0	0	0	88.00
90.00	09000	CLINIC	58,100	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	4,032,081	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,212,680	445	100	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	602,046	2,371	321,613	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.016625	5.328090	3,216.130000	0.000000	0.000000	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/19/2023 4:25 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	46,500	22	3,108	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001284	0.049438	31.080000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/19/2023 4:25 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)		
			22.00	23.00		
		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
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING PROGRAM				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
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
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
76.00	03950	CARDIAC REHAB	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	PROVIDER BASED CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0		99.40
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		192.00
192.01	19201	LIFELINE	0	0		192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0		192.02
192.03	19203	COMMUNITY BENEFIT	0	0		192.03
192.04	19204	RENTAL PROPERTIES	0	0		192.04
194.00	07950	FOUNDATION	0	0		194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000		203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/19/2023 4:25 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)		
			22.00	23.00		
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet C Part I Date/Time Prepared: 9/19/2023 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,308,908		2,308,908	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	933,174		933,174	0	0	50.00
53.00	05300	ANESTHESIOLOGY	337,970		337,970	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,604,272		1,604,272	0	0	54.00
60.00	06000	LABORATORY	1,779,489		1,779,489	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,915		2,915	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	216,391		216,391	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	264,442	0	264,442	0	0	65.00
66.00	06600	PHYSICAL THERAPY	878,161	0	878,161	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	217,692		217,692	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	690,499		690,499	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	143,295		143,295	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,043,539		1,043,539	0	0	73.00
76.00	03950	CARDIAC REHAB	162,819		162,819	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,019,303		4,019,303	0	0	88.00
90.00	09000	CLINIC	11,009		11,009	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0		0	0	0	90.01
91.00	09100	EMERGENCY	4,379,061		4,379,061	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,234,877		1,234,877		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	20,227,816	0	20,227,816	0	0	200.00
201.00		Less Observation Beds	1,234,877		1,234,877		0	201.00
202.00		Total (see instructions)	18,992,939	0	18,992,939	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet C Part I Date/Time Prepared: 9/19/2023 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	286,968		286,968			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	501,485	1,208,299	1,709,784	0.545785	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	314,383	661,400	975,783	0.346358	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	125,347	9,067,764	9,193,111	0.174508	0.000000	54.00
60.00	06000	LABORATORY	201,519	6,773,006	6,974,525	0.255141	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,419	28,789	30,208	0.096498	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	97,161	1,527,541	1,624,702	0.133188	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	45,138	217,828	262,966	1.005613	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	8,662	3,826,654	3,835,316	0.228967	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	10,709	688,775	699,484	0.311218	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	616,674	299,496	916,170	0.753680	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	144,252	144,252	0.993366	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	243,179	1,275,498	1,518,677	0.687137	0.000000	73.00
76.00	03950	CARDIAC REHAB	0	158,517	158,517	1.027139	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,423,068	3,423,068			88.00
90.00	09000	CLINIC	0	58,100	58,100	0.189484	0.000000	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	48,843	3,983,238	4,032,081	1.086055	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	27,020	341,948	368,968	3.346840	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	2,528,507	33,684,173	36,212,680			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,528,507	33,684,173	36,212,680			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet C Part I Date/Time Prepared: 9/19/2023 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03950	CARDIAC REHAB	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	PROVIDER BASED CLINIC	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
99.10	09910	CORF		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY		99.40
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet C Part I Date/Time Prepared: 9/19/2023 4:25 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	2,308,908		2,308,908	0	2,308,908	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	933,174		933,174	0	933,174	50.00
53.00	05300	ANESTHESIOLOGY	337,970		337,970	0	337,970	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,604,272		1,604,272	0	1,604,272	54.00
60.00	06000	LABORATORY	1,779,489		1,779,489	0	1,779,489	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,915		2,915	0	2,915	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	216,391		216,391	0	216,391	64.00
65.00	06500	RESPIRATORY THERAPY	264,442	0	264,442	0	264,442	65.00
66.00	06600	PHYSICAL THERAPY	878,161	0	878,161	0	878,161	66.00
69.00	06900	ELECTROCARDIOLOGY	217,692		217,692	0	217,692	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	690,499		690,499	0	690,499	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	143,295		143,295	0	143,295	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,043,539		1,043,539	0	1,043,539	73.00
76.00	03950	CARDIAC REHAB	162,819		162,819	0	162,819	76.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,019,303		4,019,303	0	4,019,303	88.00
90.00	09000	CLINIC	11,009		11,009	0	11,009	90.00
90.01	09001	PROVIDER BASED CLINIC	0		0	0	0	90.01
91.00	09100	EMERGENCY	4,379,061		4,379,061	0	4,379,061	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,234,877		1,234,877		1,234,877	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	20,227,816	0	20,227,816	0	20,227,816	200.00
201.00		Less Observation Beds	1,234,877		1,234,877		1,234,877	201.00
202.00		Total (see instructions)	18,992,939	0	18,992,939	0	18,992,939	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet C Part I Date/Time Prepared: 9/19/2023 4:25 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	286,968		286,968			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	501,485	1,208,299	1,709,784	0.545785	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	314,383	661,400	975,783	0.346358	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	125,347	9,067,764	9,193,111	0.174508	0.000000	54.00
60.00	06000	LABORATORY	201,519	6,773,006	6,974,525	0.255141	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,419	28,789	30,208	0.096498	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	97,161	1,527,541	1,624,702	0.133188	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	45,138	217,828	262,966	1.005613	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	8,662	3,826,654	3,835,316	0.228967	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	10,709	688,775	699,484	0.311218	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	616,674	299,496	916,170	0.753680	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	144,252	144,252	0.993366	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	243,179	1,275,498	1,518,677	0.687137	0.000000	73.00
76.00	03950	CARDIAC REHAB	0	158,517	158,517	1.027139	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,423,068	3,423,068	1.174181	0.000000	88.00
90.00	09000	CLINIC	0	58,100	58,100	0.189484	0.000000	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	48,843	3,983,238	4,032,081	1.086055	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	27,020	341,948	368,968	3.346840	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	2,528,507	33,684,173	36,212,680			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,528,507	33,684,173	36,212,680			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet C Part I Date/Time Prepared: 9/19/2023 4:25 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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03950	CARDIAC REHAB	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	PROVIDER BASED CLINIC	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
99.10	09910	CORF		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY		99.40
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part II Date/Time Prepared: 9/19/2023 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	126,123	1,709,784	0.073765	13,450	992	50.00
53.00	05300	ANESTHESIOLOGY	1,254	975,783	0.001285	9,351	12	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,354	9,193,111	0.007870	84,432	664	54.00
60.00	06000	LABORATORY	54,829	6,974,525	0.007861	74,693	587	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	65	30,208	0.002152	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	10,681	1,624,702	0.006574	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	10,888	262,966	0.041405	38,650	1,600	65.00
66.00	06600	PHYSICAL THERAPY	62,935	3,835,316	0.016409	7,436	122	66.00
69.00	06900	ELECTROCARDIOLOGY	8,678	699,484	0.012406	2,939	36	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,222	916,170	0.030804	50,986	1,571	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,056	144,252	0.041982	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,498	1,518,677	0.014814	90,983	1,348	73.00
76.00	03950	CARDIAC REHAB	13,361	158,517	0.084287	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	238,407	3,423,068	0.069647	0	0	88.00
90.00	09000	CLINIC	183	58,100	0.003150	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	121,798	4,032,081	0.030207	3,034	92	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	94,760	368,968	0.256824	0	0	92.00
200.00		Total (lines 50 through 199)	873,092	35,925,712		375,954	7,024	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part IV Date/Time Prepared: 9/19/2023 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	321,613	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
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
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	321,613	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part IV Date/Time Prepared: 9/19/2023 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,709,784	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	321,613	0	975,783	0.329595	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,193,111	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	6,974,525	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	30,208	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,624,702	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	262,966	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,835,316	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	699,484	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	916,170	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	144,252	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,518,677	0.000000	73.00
76.00	03950	CARDIAC REHAB	0	0	0	158,517	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,423,068	0.000000	88.00
90.00	09000	CLINIC	0	0	0	58,100	0.000000	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	4,032,081	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	368,968	0.000000	92.00
200.00		Total (lines 50 through 199)	0	321,613	0	35,925,712		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part IV Date/Time Prepared: 9/19/2023 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	13,450	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	9,351	3,082	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	84,432	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	74,693	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	38,650	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	7,436	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,939	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	50,986	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	90,983	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
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
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	3,034	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)		375,954	3,082	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part V Date/Time Prepared: 9/19/2023 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.545785	0	245,045	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.346358	0	138,150	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174508	0	2,762,032	0	0	54.00
60.00	06000	LABORATORY	0.255141	0	1,848,809	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.096498	0	15,985	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.133188	0	383,717	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1.005613	0	54,632	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.228967	0	1,150,051	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.311218	0	217,381	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.753680	0	64,464	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.993366	0	18,375	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.687137	0	559,394	0	0	73.00
76.00	03950	CARDIAC REHAB	1.027139	0	104,088	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0.189484	0	16,260	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	1.086055	0	808,879	15,922	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3.346840	0	107,421	0	0	92.00
200.00		Subtotal (see instructions)		0	8,494,683	15,922	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	8,494,683	15,922	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part V Date/Time Prepared: 9/19/2023 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	133,742	0		50.00
53.00	05300	ANESTHESIOLOGY	47,849	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	481,997	0		54.00
60.00	06000	LABORATORY	471,707	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,543	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400	INTRAVENOUS THERAPY	51,106	0		64.00
65.00	06500	RESPIRATORY THERAPY	54,939	0		65.00
66.00	06600	PHYSICAL THERAPY	263,324	0		66.00
69.00	06900	ELECTROCARDIOLOGY	67,653	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	48,585	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,253	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	384,380	0		73.00
76.00	03950	CARDIAC REHAB	106,913	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	3,081	0		90.00
90.01	09001	PROVIDER BASED CLINIC	0	0		90.01
91.00	09100	EMERGENCY	878,487	17,292		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	359,521	0		92.00
200.00		Subtotal (see instructions)	3,373,080	17,292		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,373,080	17,292		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1303 | Component CCN: 14-Z303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part IV | Date/Time Prepared: 9/19/2023 4:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	321,613	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
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
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	321,613	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1303 | Component CCN: 14-Z303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part IV | Date/Time Prepared: 9/19/2023 4:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,709,784	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	321,613	0	975,783	0.329595	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,193,111	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	6,974,525	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	30,208	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,624,702	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	262,966	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,835,316	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	699,484	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	916,170	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	144,252	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,518,677	0.000000	73.00
76.00	03950	CARDIAC REHAB	0	0	0	158,517	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,423,068	0.000000	88.00
90.00	09000	CLINIC	0	0	0	58,100	0.000000	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	4,032,081	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	368,968	0.000000	92.00
200.00		Total (lines 50 through 199)	0	321,613	0	35,925,712		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1303 | Component CCN: 14-Z303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part IV | Date/Time Prepared: 9/19/2023 4:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
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
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	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)		0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1303 | Component CCN: 14-Z303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part V | Date/Time Prepared: 9/19/2023 4:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.545785	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.346358	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174508	0	0	0	0	54.00
60.00	06000	LABORATORY	0.255141	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.096498	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.133188	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1.005613	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.228967	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.311218	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.753680	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.993366	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.687137	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	1.027139	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0.189484	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	1.086055	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3.346840	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1303 | Component CCN: 14-Z303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part V | Date/Time Prepared: 9/19/2023 4:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
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
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
76.00	03950	CARDIAC REHAB	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	PROVIDER BASED CLINIC	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)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D-1 | Date/Time Prepared: 9/19/2023 4:25 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	445	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	445	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)	207	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)	119	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	120.63	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	131.13	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,308,908	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)	2,308,908	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,308,908	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)	5,188.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	617,439	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)	617,439	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D-1 | Date/Time Prepared: 9/19/2023 4:25 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	190,096	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)	807,535	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	238	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	5,188.56	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1303	Period: From 05/01/2022 To 04/30/2023	Worksheet D-1 Date/Time Prepared: 9/19/2023 4:25 pm
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,234,877	89.00

	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	177,177	2,308,908	0.076736	1,234,877	94,760	90.00
91.00	Nursing Program cost	0	2,308,908	0.000000	1,234,877	0	91.00
92.00	Allied health cost	0	2,308,908	0.000000	1,234,877	0	92.00
93.00	All other Medical Education	0	2,308,908	0.000000	1,234,877	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D-1 | Date/Time Prepared: 9/19/2023 4:25 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	445	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	445	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)	207	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)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	120.63	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	131.13	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,308,908	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)	2,308,908	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,308,908	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)	5,188.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D-1 | Date/Time Prepared: 9/19/2023 4:25 pm

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	0	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	238	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	5,188.56	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1303	Period: From 05/01/2022 To 04/30/2023	Worksheet D-1 Date/Time Prepared: 9/19/2023 4:25 pm
	Title XIX	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,234,877	89.00

	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	177,177	2,308,908	0.076736	1,234,877	94,760	90.00
91.00	Nursing Program cost	0	2,308,908	0.000000	1,234,877	0	91.00
92.00	Allied health cost	0	2,308,908	0.000000	1,234,877	0	92.00
93.00	All other Medical Education	0	2,308,908	0.000000	1,234,877	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D-3 | Date/Time Prepared: 9/19/2023 4:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		192,891		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.545785	13,450	7,341	50.00
53.00	05300	ANESTHESIOLOGY	0.346358	9,351	3,239	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174508	84,432	14,734	54.00
60.00	06000	LABORATORY	0.255141	74,693	19,057	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.096498	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.133188	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1.005613	38,650	38,867	65.00
66.00	06600	PHYSICAL THERAPY	0.228967	7,436	1,703	66.00
69.00	06900	ELECTROCARDIOLOGY	0.311218	2,939	915	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.753680	50,986	38,427	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.993366	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.687137	90,983	62,518	73.00
76.00	03950	CARDIAC REHAB	1.027139	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.189484	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0.000000	0	0	90.01
91.00	09100	EMERGENCY	1.086055	3,034	3,295	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3.346840	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		375,954	190,096	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)		375,954		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1303 | Component CCN: 14-Z303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D-3 | Date/Time Prepared: 9/19/2023 4:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.545785	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.346358	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174508	0	0	54.00
60.00	06000	LABORATORY	0.255141	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.096498	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.133188	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1.005613	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.228967	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.311218	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.753680	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.993366	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.687137	0	0	73.00
76.00	03950	CARDIAC REHAB	1.027139	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.189484	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0.000000	0	0	90.01
91.00	09100	EMERGENCY	1.086055	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3.346840	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1303	Period: From 05/01/2022 To 04/30/2023	Worksheet E Part B Date/Time Prepared: 9/19/2023 4:25 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,390,372	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,390,372	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	3,424,276	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	29,192	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,293,892	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)	2,101,192	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)	2,101,192	30.00
31.00	Primary payer payments	469	31.00
32.00	Subtotal (line 30 minus line 31)	2,100,723	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)	145,351	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	94,478	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	90,340	36.00
37.00	Subtotal (see instructions)	2,195,201	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)	2,195,201	40.00
40.01	Sequestration adjustment (see instructions)	40,392	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	2,152,787	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)	2,022	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1303	Period: From 05/01/2022 To 04/30/2023	Worksheet E Part B Date/Time Prepared: 9/19/2023 4:25 pm
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet E-1 Part I Date/Time Prepared: 9/19/2023 4:25 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		510,472		2,278,850	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		10/19/2022	14,890	10/19/2022	55,789	3.02
3.03		04/19/2023	57,750		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	04/19/2023	181,852	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)		72,640		-126,063	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)		583,112		2,152,787	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		171,722		2,022	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		754,834		2,154,809	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1303 | Component CCN: 14-Z303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 9/19/2023 4:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1303	Period: From 05/01/2022 To 04/30/2023	Worksheet E-1 Part II Date/Time Prepared: 9/19/2023 4:25 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-1303 | Component CCN: 14-Z303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet E-2 | Date/Time Prepared: 9/19/2023 4:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	0	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	0	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1303	Period: From 05/01/2022 To 04/30/2023	Worksheet E-3 Part V Date/Time Prepared: 9/19/2023 4:25 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	807,535	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	807,535	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	815,610	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	815,610	19.00
20.00	Deductibles (exclude professional component)	55,032	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	760,578	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	760,578	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	12,931	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	8,405	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	11,375	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	768,983	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	768,983	30.00
30.01	Sequestration adjustment (see instructions)	14,149	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	583,112	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	171,722	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1303	Period: From 05/01/2022 To 04/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 9/19/2023 4:25 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		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	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	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	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	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet G | Date/Time Prepared: 9/19/2023 4:25 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	2,892,568	0	0	0	1.00
2.00	Temporary investments	14,515,663	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,209,540	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,981,269	0	0	0	6.00
7.00	Inventory	393,642	0	0	0	7.00
8.00	Prepaid expenses	554,418	0	0	0	8.00
9.00	Other current assets	79,102	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)	20,663,664	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	545,501	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	12,815,167	0	0	0	15.00
16.00	Accumulated depreciation	-9,933,617	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	558,730	0	0	0	19.00
20.00	Accumulated depreciation	-160,474	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	6,225,776	0	0	0	23.00
24.00	Accumulated depreciation	-4,328,175	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	1,007,286	0	0	0	27.00
28.00	Accumulated depreciation	-1,007,286	0	0	0	28.00
29.00	Minor equipment-nondepreciable	307,216	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	6,030,124	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	5,586,185	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	3,169,128	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,755,313	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	35,449,101	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	800,462	0	0	0	37.00
38.00	Salaries, wages, and fees payable	939,750	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	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,740,212	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	3,585,424	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,585,424	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,325,636	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	30,123,465				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)	30,123,465	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	35,449,101	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet G-1 | Date/Time Prepared: 9/19/2023 4:25 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		28,277,323		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,705,707				2.00
3.00	Total (sum of line 1 and line 2)		29,983,030		0		3.00
4.00	CAPITAL GRANTS AND GIFTS	142,243		0		0	4.00
5.00	UNREALIZED GAINS	0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		142,243		0		10.00
11.00	Subtotal (line 3 plus line 10)		30,125,273		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	UNREALIZED LOSSES	1,808		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)		1,808		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		30,123,465		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	CAPITAL GRANTS AND GIFTS		0		4.00
5.00	UNREALIZED GAINS		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	UNREALIZED LOSSES		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: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 9/19/2023 4:25 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	286,968		286,968	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)	286,968		286,968	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	286,968		286,968	17.00
18.00	Ancillary services	2,241,539	30,261,105	32,502,644	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	3,423,068	3,423,068	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	217,860	217,860	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,528,507	33,902,033	36,430,540	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,786,074		29.00
30.00	BAD DEBT EXPENSE	1,088,895			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)		1,088,895		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)		21,874,969		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1303 | Period: From 05/01/2022 To 04/30/2023 | Worksheet G-3 | Date/Time Prepared: 9/19/2023 4:25 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	36,430,540	1.00
2.00	Less contractual allowances and discounts on patients' accounts	14,054,210	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,376,330	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,874,969	4.00
5.00	Net income from service to patients (line 3 minus line 4)	501,361	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	157,650	6.00
7.00	Income from investments	152,622	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	123,323	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	6,228	17.00
18.00	Revenue from sale of medical records and abstracts	2,630	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	861	21.00
22.00	Rental of hospital space	39,685	22.00
23.00	Governmental appropriations	0	23.00
24.00	PHARM 340B RETAIL/CONTRACT REV	606,601	24.00
24.01	CARES/ARP PRF FUNDING RECOGNIZED	0	24.01
24.02	OTHER OPERATING REVENUE	114,746	24.02
24.03	OTHER (SPECIFY)	0	24.03
24.04	OTHER (SPECIFY)	0	24.04
24.05	OTHER (SPECIFY)	0	24.05
24.06	OTHER (SPECIFY)	0	24.06
24.07	OTHER (SPECIFY)	0	24.07
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,204,346	25.00
26.00	Total (line 5 plus line 25)	1,705,707	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
27.01	OTHER EXPENSES (SPECIFY)	0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,705,707	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1303 | Component CCN: 14-3404 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-1 | Date/Time Prepared: 9/19/2023 4:25 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	746,714	0	746,714	90,561	837,275	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	363,844	0	363,844	54,377	418,221	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	324,205	0	324,205	0	324,205	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	332,537	52,093	384,630	0	384,630	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,767,300	52,093	1,819,393	144,938	1,964,331	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	80,953	80,953	-6,514	74,439	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	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	80,953	80,953	-6,514	74,439	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,767,300	133,046	1,900,346	138,424	2,038,770	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	5,635	0	5,635	0	5,635	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)	5,635	0	5,635	0	5,635	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	20,237	20,237	0	20,237	29.00
30.00	Administrative Costs	126,465	103,707	230,172	-8,394	221,778	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	126,465	123,944	250,409	-8,394	242,015	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,899,400	256,990	2,156,390	130,030	2,286,420	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1303 | Component CCN: 14-3404 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-1 | Date/Time Prepared: 9/19/2023 4:25 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	837,275		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	418,221		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	324,205		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	384,630		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,964,331		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	74,439		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	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	74,439		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,038,770		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	5,635		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	5,635		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	20,237		29.00
30.00	Administrative Costs	0	221,778		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	242,015		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,286,420		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1303 | Component CCN: 14-3404 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-2 | Date/Time Prepared: 9/19/2023 4:25 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	1.65	13,153	4,200	6,930		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.11	822	2,100	4,431		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.76	13,975		11,361	13,975	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.01	24			24	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)	3.77	13,999			13,999	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,038,770	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					5,635	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,044,405	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.997244	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					242,015	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,732,883	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,974,898	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,974,898	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,969,455	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,008,225	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1303 Component CCN: 14-3404	Period: From 05/01/2022 To 04/30/2023	Worksheet M-3 Date/Time Prepared: 9/19/2023 4:25 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)		4,008,225	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		102,288	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		3,905,937	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		13,999	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)		13,999	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		279.02	7.00
		Calculation of Limit (1)		
		Rate Period 1 (05/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 04/30/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	241.16	250.33	8.00
9.00	Rate for Program covered visits (see instructions)	241.16	250.33	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	3,131	1,566	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	755,072	392,017	11.00
12.00	Program covered visits for mental health services (from contractor records)	16	8	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	3,859	2,003	13.00
14.00	Limit adjustment for mental health services (see instructions)	3,859	2,003	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,152,951	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,135,027	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		80,856	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		82,133	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.)		781,540	16.04
16.05	Total program cost (see instructions)	0	863,673	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		93,893	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		188,989	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		863,673	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		44,428	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		908,101	22.00
23.00	Allowable bad debts (see instructions)		103,911	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		67,542	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		98,004	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)		975,643	26.00
26.01	Sequestration adjustment (see instructions)		17,952	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		842,847	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)		114,844	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: 14-1303 | Component CCN: 14-3404 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-4 | Date/Time Prepared: 9/19/2023 4:25 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)	1,964,331	1,964,331	1,964,331	1,964,331	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000590	0.001750	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,159	3,438	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	30,058	17,373	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	31,217	20,811	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,038,770	2,038,770	2,038,770	2,038,770	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,969,455	1,969,455	1,969,455	1,969,455	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.015312	0.010208	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	30,156	20,104	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	61,373	40,915	0	0	10.00
11.00	Total number of injections/infusions (from your records)	132	394	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	464.95	103.85	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	52	195	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)	24,177	20,251	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)		102,288	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)		44,428	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1303 Component CCN: 14-3404	Period: From 05/01/2022 To 04/30/2023	Worksheet M-5 Date/Time Prepared: 9/19/2023 4:25 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		842,847	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	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)		842,847	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			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		114,844	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		957,691	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101		8.00