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: 14-1351	Period: From 03/01/2022 To 02/28/2023	Worksheet S Parts I-III Date/Time Prepared: 7/21/2023 11:47 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/21/2023 Time: 11:47 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CLAY COUNTY HOSPITAL (14-1351) for the cost reporting period beginning 03/01/2022 and ending 02/28/2023 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				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				2
3	Signatory Title				3
4	Date				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	519,590	161,462	0	31,272	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	29,597	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		285,091		0	10.00
10.01	RURAL HEALTH CLINIC II	0		0		0	10.01
10.02	RURAL HEALTH CLINIC III	0		0		0	10.02
200.00	TOTAL	0	549,187	446,553	0	31,272	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: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-2 Part I Date/Time Prepared: 7/21/2023 11:47 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 911 STACY BURK DRIVE	PO Box:			1.00
2.00	City: FLORA	State: IL	Zip Code: 62839-0280	County: CLAY	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	CLAY COUNTY HOSPITAL	141351	99914	1	12/21/2005	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	CLAY COUNTY SWING BED	14Z351	99914		12/21/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	CLAY COUNTY MEDICAL CLINIC	143458	99914		11/29/2005	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	LOUISVILLE MEDICAL CLINIC	143487	99914		12/18/2006	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	CLAY COUNTY HOSPITAL CLAY CITY CLINI	148558	99914		09/02/2016	N	O	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	03/01/2022	02/28/2023	20.00
21.00	Type of Control (see instructions)	9		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.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-2 Part I | Date/Time Prepared: 7/21/2023 11:47 am

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1351	Period: From 03/01/2022 To 02/28/2023	Worksheet S-2 Part I Date/Time Prepared: 7/21/2023 11:47 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-2 Part I Date/Time Prepared: 7/21/2023 11:47 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-2 Part I Date/Time Prepared: 7/21/2023 11:47 am

			1.00		
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)				
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?		N		68.00
		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
	Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
	TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments		
		1.00	2.00		
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		0		88.00
		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		0	89.00
		V	XIX		
		1.00	2.00		
	Title V and XIX Services				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	N		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.	Y	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: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-2 Part I Date/Time Prepared: 7/21/2023 11:47 am

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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.	N	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.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
113.00	Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.				113.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	230,685	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
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	HB2404	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: SSM HEALTHCARE SOUTHERN ILLINOIS	Contractor's Name: NATIONAL GOVT SERVICES	Contractor's Number: 06101	141.00
142.00	Street: 1 GOOD SAMARITAN WAY	PO Box:		142.00
143.00	City: MOUNT VERNON	State: IL	Zip Code: 62864	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	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
					1.00	
	Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-2 Part II | Date/Time Prepared: 7/21/2023 11:47 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	08/11/2023	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.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	07/18/2023	Y	07/18/2023	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

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		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEN		JANOWSKI		41.00
42.00	Enter the employer/company name of the cost report preparer.	STRATEGIC REIMBURSEMENT GROUP LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	480-206-6615		KEN.JANOWSKI@SRGROUPLLC.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.	VICE PRESIDENT		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: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-3 Part I Date/Time Prepared: 7/21/2023 11:47 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	20	7,300	39,552.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		20	7,300	39,552.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		20	7,300	39,552.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		20				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

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	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,231	11	1,648			1.00
2.00	HMO and other (see instructions)	66	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	344	0	354			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	84			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,575	11	2,086			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,575	11	2,086	0.00	177.27	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	7,476	0	29,198	0.00	46.83	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	224.10	27.00
28.00	Observation Bed Days		36	441			28.00
29.00	Ambulance Trips	1,098					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: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-3 Part I | Date/Time Prepared: 7/21/2023 11:47 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	279	4	381	1.00
2.00	HMO and other (see instructions)			16	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	279	4	381	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	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: 14-1351 | Component CCN: 14-3458 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-8 | Date/Time Prepared: 7/21/2023 11:47 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			929 STACY BURK DRIVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	FLORA		IL	62839	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y	3	13.00

		Provider name	CCN	
		1.00	2.00	
14.00	RHC/FQHC name, CCN	CLAY COUNTY HOSPITAL CLIN	143458	14.00
14.01		LOUISVILLE MEDICAL CLINIC	143487	14.01
14.02		CLAY CITY CLINIC	148558	14.02

		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		CLAY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1351 | Component CCN: 14-3458 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-8 | Date/Time Prepared: 7/21/2023 11:47 am

RHC I | Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-10 | Date/Time Prepared: 7/21/2023 11:47 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.361461	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,505,963	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	14,440,573	6.00
7.00	Medicaid cost (line 1 times line 6)	5,219,704	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,713,741	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	100,115	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,713,741	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)	71,419	1,356,968	1,428,387	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	25,815	1,356,968	1,382,783	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	25,815	1,356,968	1,382,783	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)	2,073,867	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	665,824	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,024,344	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,049,523	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	737,882	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,120,665	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,834,406	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A | Date/Time Prepared: 7/21/2023 11:47 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		298,340	298,340	29,022	327,362	1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT		9,573	9,573	200,915	210,488	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,066,309	1,066,309	748	1,067,057	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	160,407	5,706,019	5,866,426	-166,002	5,700,424	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	127,762	4,011	131,773	-13,307	118,466	5.01
5.02	00570	ADMITTING	124,597	1,137	125,734	268,956	394,690	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	557,266	236,404	793,670	-268,981	524,689	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	405,357	2,581,501	2,986,858	-234,702	2,752,156	5.04
7.00	00700	OPERATION OF PLANT	289,550	525,390	814,940	-1	814,939	7.00
7.01	00701	RHC UTILITY EXPENSE	0	50,588	50,588	0	50,588	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	148,816	148,816	32,548	181,364	8.00
9.00	00900	HOUSEKEEPING	407,623	43,442	451,065	-19,488	431,577	9.00
10.00	01000	DIETARY	420,141	169,924	590,065	-297,616	292,449	10.00
11.00	01100	CAFETERIA	0	0	0	308,446	308,446	11.00
13.00	01300	NURSING ADMINISTRATION	718,969	43,347	762,316	0	762,316	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	47,868	76,032	123,900	0	123,900	14.00
15.00	01500	PHARMACY	219,547	104,894	324,441	0	324,441	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	471,501	82,713	554,214	0	554,214	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,559,169	618,064	2,177,233	0	2,177,233	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	387,586	160,079	547,665	33,124	580,789	50.00
53.00	05300	ANESTHESIOLOGY	0	351,371	351,371	-33,371	318,000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	470,477	783,248	1,253,725	-507	1,253,218	54.00
60.00	06000	LABORATORY	691,278	1,409,358	2,100,636	-157	2,100,479	60.00
65.00	06500	RESPIRATORY THERAPY	576,226	67,299	643,525	-115,507	528,018	65.00
66.00	06600	PHYSICAL THERAPY	589,932	66,663	656,595	-200	656,395	66.00
69.00	06900	ELECTROCARDIOLOGY	0	29,646	29,646	86,434	116,080	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	64,361	64,361	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	433,867	433,867	0	433,867	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	90,466	1,098,317	1,188,783	-132	1,188,651	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	228,862	13,003	241,865	-2,646	239,219	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,347,469	316,942	4,664,411	124,152	4,788,563	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	5,010	5,010	90.00
91.00	09100	EMERGENCY	1,058,577	1,068,554	2,127,131	-1,099	2,126,032	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,036,977	91,767	1,128,744	0	1,128,744	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,987,607	17,656,618	32,644,225	0	32,644,225	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	37,458	31,810	69,268	0	69,268	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	15,025,065	17,688,428	32,713,493	0	32,713,493	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A | Date/Time Prepared: 7/21/2023 11:47 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	929,953	1,257,315		1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT	0	210,488		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	141,832	1,208,889		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,060,002	4,640,422		4.00
5.01	00560	PURCHASING RECEIVING AND STORES	0	118,466		5.01
5.02	00570	ADMITTING	0	394,690		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	-96	524,593		5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	2,821,601	5,573,757		5.04
7.00	00700	OPERATION OF PLANT	0	814,939		7.00
7.01	00701	RHC UTILITY EXPENSE	0	50,588		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	181,364		8.00
9.00	00900	HOUSEKEEPING	0	431,577		9.00
10.00	01000	DIETARY	0	292,449		10.00
11.00	01100	CAFETERIA	-133,333	175,113		11.00
13.00	01300	NURSING ADMINISTRATION	-3,735	758,581		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	123,900		14.00
15.00	01500	PHARMACY	0	324,441		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-10,508	543,706		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-400,759	1,776,474		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	580,789		50.00
53.00	05300	ANESTHESIOLOGY	-318,000	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-5,226	1,247,992		54.00
60.00	06000	LABORATORY	-12,001	2,088,478		60.00
65.00	06500	RESPIRATORY THERAPY	-1,701	526,317		65.00
66.00	06600	PHYSICAL THERAPY	-5,000	651,395		66.00
69.00	06900	ELECTROCARDIOLOGY	-23,163	92,917		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	64,361		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	433,867		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-484,809	703,842		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	239,219		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-124,674	4,663,889		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	0	5,010		90.00
91.00	09100	EMERGENCY	-4,250	2,121,782		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	1,128,744		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,306,129	33,950,354		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	69,268		192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	1,306,129	34,019,622		200.00

RECLASSIFICATIONS | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A-6 | Date/Time Prepared: 7/21/2023 11:47 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DEPRICIATION					
1.00	NEW CAP RHC REL COSTS-BLDG & FIXT	1.01	0	166,368		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	166,368		
	B - RESPIRATORY THERAPY					
1.00	ELECTROCARDIOLOGY	69.00	86,434	0		1.00
2.00	ELECTROENCEPHALOGRAPHY	70.00	28,811	0		2.00
	TOTALS		115,245	0		
	C - INSURANCE EXPENSE					
1.00	NEW CAP RHC REL COSTS-BLDG & FIXT	1.01	0	34,547		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	33,587		2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	162,551		3.00
	TOTALS		0	230,685		
	D - OPERATING ROOM					
1.00	OPERATING ROOM	50.00	0	33,371		1.00
	TOTALS		0	33,371		
	E - RECLASS PORTION OF DIETARY TO CAFE					
1.00	CAFETERIA	11.00	206,272	102,174		1.00
	TOTALS		206,272	102,174		
	G - DIEBETIES EDUCATION					
1.00	CLINIC	90.00	4,670	340		1.00
	TOTALS		4,670	340		
	H - SLEEP LAB PURCHASE SERVICE					
1.00	ELECTROENCEPHALOGRAPHY	70.00	0	35,550		1.00
	TOTALS		0	35,550		
	J - CONSOLIDATE DIETARY TRANSFERS					
1.00	DIETARY	10.00	0	10,830		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
	TOTALS		0	10,830		
	K - REGISTRATION PERSONNEL					
1.00	ADMITTING	5.02	188,850	80,106		1.00
	TOTALS		188,850	80,106		
	L - LAUNDRY SALARIES					
1.00	LAUNDRY & LINEN SERVICE	8.00	30,289	2,259		1.00
2.00		0.00	0	0		2.00
	TOTALS		30,289	2,259		
	M - RHC PHYSICIAN BENEFITS					
1.00	RURAL HEALTH CLINIC	88.00	0	165,992		1.00
	TOTALS		0	165,992		
500.00	Grand Total: Increases		545,326	827,675		500.00

RECLASSIFICATIONS | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A-6 | Date/Time Prepared: 7/21/2023 11:47 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRICIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	133,529	9		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	32,839	9		2.00
	TOTALS		0	166,368			
	B - RESPIRATORY THERAPY						
1.00	RESPIRATORY THERAPY	65.00	115,245	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		115,245	0			
	C - INSURANCE EXPENSE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	230,685	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	230,685			
	D - OPERATING ROOM						
1.00	ANESTHESIOLOGY	53.00	0	33,371	0		1.00
	TOTALS		0	33,371			
	E - RECLASS PORTION OF DIETARY TO CAFE						
1.00	DIETARY	10.00	206,272	102,174	0		1.00
	TOTALS		206,272	102,174			
	G - DIEBETIES EDUCATION						
1.00	RURAL HEALTH CLINIC	88.00	4,670	340	0		1.00
	TOTALS		4,670	340			
	H - SLEEP LAB PURCHASE SERVICE						
1.00	RURAL HEALTH CLINIC	88.00	0	35,550	0		1.00
	TOTALS		0	35,550			
	J - CONSOLIDATE DIETARY TRANSFERS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	10	0		1.00
2.00	PURCHASING RECEIVING AND STORES	5.01	0	24	0		2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03	0	25	0		3.00
4.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	4,017	0		4.00
5.00	OPERATION OF PLANT	7.00	0	1	0		5.00
6.00	HOUSEKEEPING	9.00	0	223	0		6.00
7.00	OPERATING ROOM	50.00	0	247	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	507	0		8.00
9.00	LABORATORY	60.00	0	157	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	262	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	200	0		11.00
12.00	DRUGS CHARGED TO PATIENTS	73.00	0	132	0		12.00
13.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	2,646	0		13.00
14.00	RURAL HEALTH CLINIC	88.00	0	1,280	0		14.00
15.00	EMERGENCY	91.00	0	1,099	0		15.00
	TOTALS		0	10,830			
	K - REGISTRATION PERSONNEL						
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03	188,850	80,106	0		1.00
	TOTALS		188,850	80,106			
	L - LAUNDRY SALARIES						
1.00	PURCHASING RECEIVING AND STORES	5.01	12,879	404	0		1.00
2.00	HOUSEKEEPING	9.00	17,410	1,855	0		2.00
	TOTALS		30,289	2,259			
	M - RHC PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	165,992	0		1.00
	TOTALS		0	165,992			
500.00	Grand Total: Decreases		545,326	827,675			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A-7 Part I | Date/Time Prepared: 7/21/2023 11:47 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	135,111	0	0	0	0	1.00
2.00	Land Improvements	351,667	0	0	0	0	2.00
3.00	Buildings and Fixtures	14,886,863	300,995	0	300,995	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	11,977,935	1,764,366	0	1,764,366	0	6.00
7.00	HIT designated Assets	1,573,806	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,925,382	2,065,361	0	2,065,361	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	28,925,382	2,065,361	0	2,065,361	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	135,111	0	1.00
2.00	Land Improvements	351,667	0	2.00
3.00	Buildings and Fixtures	15,187,858	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	13,742,301	0	6.00
7.00	HIT designated Assets	1,573,806	0	7.00
8.00	Subtotal (sum of lines 1-7)	30,990,743	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	30,990,743	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A-7 Part II | Date/Time Prepared: 7/21/2023 11:47 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	298,340	0	0	0	0	1.00
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	0	0	0	0	9,573	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	1,023,918	42,391	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,322,258	42,391	0	0	9,573	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	298,340	1.00
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	0	9,573	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,066,309	2.00
3.00	Total (sum of lines 1-2)	0	1,374,222	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A-7 Part III | Date/Time Prepared: 7/21/2023 11:47 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	15,674,636	0	15,674,636	0.505784	0	1.00
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	15,316,107	0	15,316,107	0.494216	0	2.00
3.00	Total (sum of lines 1-2)	30,990,743	0	30,990,743	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,094,764	0	1.00
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	0	0	0	166,368	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,132,911	42,391	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,394,043	42,391	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	162,551	0	0	1,257,315	1.00
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	0	34,547	9,573	0	210,488	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	33,587	0	0	1,208,889	2.00
3.00	Total (sum of lines 1-2)	0	230,685	9,573	0	2,676,692	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A-8 | Date/Time Prepared: 7/21/2023 11:47 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP RHC REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP RHC REL COSTS-BLDG & FIXT	1.01	0	1.01
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)	B	-5,000	RADIOLOGY-DIAGNOSTIC	54.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-12,001	LABORATORY	60.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-2,738	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-425,597			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-226	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	4,053,752			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-132,889	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	-543	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-10,508	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)	B	-1,720	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	19.00
20.00	Vending machines	B	-444	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP RHC REL COSTS-BLDG & FIXT		0	NEW CAP RHC REL COSTS-BLDG & FIXT	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** 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: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A-8 | Date/Time Prepared: 7/21/2023 11:47 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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	PHYSICAL THERAPY OTHER INCOME	B	-5,000	PHYSICAL THERAPY	66.00	0	33.00
34.00	MISCELLANEOUS REVENUE	B	-8,152	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	34.00
35.00	PUBLIC RELATIONS	A	-79,873	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	35.00
36.00	LOBBYING EXPENSE	A	-10,047	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	36.00
37.00	CRNA EXPENSE	A	-318,000	ANESTHESIOLOGY	53.00	0	37.00
38.00	EMPLOYEE BENEFITS LAB TESTS	A	-91,475	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	EMPLOYEE HEALTH INSURANCE REIMBURSEM	B	-677,769	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
40.00	CLAY CITY OTHER REVENUE	B	-3,764	RURAL HEALTH CLINIC	88.00	0	40.00
41.00	EMERGENCY PREPARDNESS REVENUE	B	-3,696	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	41.00
42.00	PENSION DIFFERENTIAL	A	-290,758	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	42.00
43.00	RMC MED DIRECTOR REIMBURSEMENT	B	-3,696	RURAL HEALTH CLINIC	88.00	0	43.00
44.00	BEHAVORIAL HEALTH OTHER INCOME	B	-117,214	RURAL HEALTH CLINIC	88.00	0	44.00
45.00	MED SURG OTHER INCOME	B	-26	ADULTS & PEDIATRICS	30.00	0	45.00
46.00	INFORMATION OTHER REVENUE	B	-53,597	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	46.00
47.00	BUSINESS OFFICE OTHER REVENUE	B	-96	CASHIERING/ACCOUNTS RECEIVABLE	5.03	0	47.00
48.00	PHYSICIAN FEE INCOME	B	-1,000	NURSING ADMINISTRATION	13.00	0	48.00
49.00	340B DRUG EXPENSE	A	-484,809	DRUGS CHARGED TO PATIENTS	73.00	0	49.00
49.01	EMERGENCY ROOM OTHER INCOME	B	-4,250	EMERGENCY	91.00	0	49.01
49.02	QUALITY OTHER INCOME	B	-2,735	NURSING ADMINISTRATION	13.00	0	49.02
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,306,129				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: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A-8-1 | Date/Time Prepared: 7/21/2023 11:47 am

	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	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE CAPITAL	929,953	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE CAPITAL	141,832	0	2.00
3.00	5.04	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE OPERATING	3,691,132	709,165	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.			4,762,917	709,165	5.00

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

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

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

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

6.00	G	SSM HEALTHCARE	1.00		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:	NON FINANCIAL				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-1351	Period: From 03/01/2022 To 02/28/2023	Worksheet A-8-1 Date/Time Prepared: 7/21/2023 11:47 am

	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	929,953	9		1.00
2.00	141,832	9		2.00
3.00	2,981,967	0		3.00
4.00	0	0		4.00
5.00	4,053,752			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			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: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A-8-2 | Date/Time Prepared: 7/21/2023 11:47 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. H	466,156	400,733	65,423	0	0	1.00
2.00	60.00	DR. L	24,250	0	24,250	0	0	2.00
3.00	65.00	DR. R	1,701	1,701	0	0	0	3.00
4.00	69.00	DR. K	16,616	16,616	0	0	0	4.00
5.00	69.00	DR. M	6,547	6,547	0	0	0	5.00
6.00	91.00	DR. E	1,006,678	0	1,006,678	0	0	6.00
7.00	50.00	DR. A	24,000	0	24,000	0	0	7.00
8.00	0.00	AGGREGATE-	0	0	0	0	0	8.00
9.00	0.00	AGGREGATE-	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,545,948	425,597	1,120,351		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	DR. H	0	0	0	0	0	1.00
2.00	60.00	DR. L	0	0	0	0	0	2.00
3.00	65.00	DR. R	0	0	0	0	0	3.00
4.00	69.00	DR. K	0	0	0	0	0	4.00
5.00	69.00	DR. M	0	0	0	0	0	5.00
6.00	91.00	DR. E	0	0	0	0	0	6.00
7.00	50.00	DR. A	0	0	0	0	0	7.00
8.00	0.00	AGGREGATE-	0	0	0	0	0	8.00
9.00	0.00	AGGREGATE-	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	DR. H	0	0	0	400,733		1.00
2.00	60.00	DR. L	0	0	0	0		2.00
3.00	65.00	DR. R	0	0	0	1,701		3.00
4.00	69.00	DR. K	0	0	0	16,616		4.00
5.00	69.00	DR. M	0	0	0	6,547		5.00
6.00	91.00	DR. E	0	0	0	0		6.00
7.00	50.00	DR. A	0	0	0	0		7.00
8.00	0.00	AGGREGATE-	0	0	0	0		8.00
9.00	0.00	AGGREGATE-	0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	425,597		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B Part I | Date/Time Prepared: 7/21/2023 11:47 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW CAP RHC REL COSTS-BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,257,315	1,257,315				1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT	210,488	0	210,488			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,208,889			1,208,889		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,640,422	0	0	0	4,640,422	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	118,466	29,618	0	28,625	39,238	5.01
5.02	00570	ADMITTING	394,690	10,267	0	9,923	107,058	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	524,593	0	5,164	0	125,832	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	5,573,757	616,495	14,901	595,830	138,450	5.04
7.00	00700	OPERATION OF PLANT	814,939	9,687	0	9,363	98,896	7.00
7.01	00701	RHC UTILITY EXPENSE	50,588	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	181,364	4,807	0	4,646	10,345	8.00
9.00	00900	HOUSEKEEPING	431,577	2,247	0	2,171	133,277	9.00
10.00	01000	DIETARY	292,449	22,588	0	21,831	73,047	10.00
11.00	01100	CAFETERIA	175,113	7,247	0	7,005	70,452	11.00
13.00	01300	NURSING ADMINISTRATION	758,581	6,064	5,164	5,860	245,564	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	123,900	10,533	0	10,180	16,349	14.00
15.00	01500	PHARMACY	324,441	10,146	0	9,806	74,986	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	543,706	0	20,065	0	161,041	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,776,474	147,558	0	142,612	532,534	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	580,789	98,252	0	94,958	132,380	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,247,992	72,571	0	70,139	160,691	54.00
60.00	06000	LABORATORY	2,088,478	28,942	0	27,971	236,106	60.00
65.00	06500	RESPIRATORY THERAPY	526,317	25,414	0	24,563	157,448	65.00
66.00	06600	PHYSICAL THERAPY	651,395	6,474	12,356	6,257	201,491	66.00
69.00	06900	ELECTROCARDIOLOGY	92,917	8,117	0	7,845	29,522	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	64,361	8,093	4,197	7,822	9,840	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	433,867	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	703,842	6,813	0	6,584	30,899	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	239,219	28,120	2,582	27,178	78,168	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,663,889	0	130,088	0	1,046,683	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	5,010	0	590	0	1,595	90.00
91.00	09100	EMERGENCY	2,121,782	60,710	0	58,675	361,557	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,128,744	30,053	0	29,045	354,179	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,950,354	1,250,816	195,107	1,208,889	4,627,628	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,499	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	69,268	0	15,381	0	12,794	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	34,019,622	1,257,315	210,488	1,208,889	4,640,422	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B Part I | Date/Time Prepared: 7/21/2023 11:47 am

		Cost Center Description	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
			5.01	5.02	5.03	5A.03	5.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES	215,947					5.01
5.02	00570	ADMITTING	361	522,299				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	702	0	656,291			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	8,786	0	0	6,948,219	6,948,219	5.04
7.00	00700	OPERATION OF PLANT	875	0	0	933,760	263,131	7.00
7.01	00701	RHC UTILITY EXPENSE	0	0	0	50,588	14,256	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	15,858	0	0	217,020	61,156	8.00
9.00	00900	HOUSEKEEPING	3,896	0	0	573,168	161,517	9.00
10.00	01000	DIETARY	7,064	0	0	416,979	117,503	10.00
11.00	01100	CAFETERIA	10,653	0	0	270,470	76,218	11.00
13.00	01300	NURSING ADMINISTRATION	307	0	0	1,021,540	287,867	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,854	0	0	166,816	47,008	14.00
15.00	01500	PHARMACY	336	0	0	419,715	118,274	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	444	0	0	725,256	204,375	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,187	156,236	37,840	2,797,441	788,310	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,669	37,116	44,744	994,908	280,362	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,287	41,344	183,519	1,778,543	501,188	54.00
60.00	06000	LABORATORY	1,068	64,961	120,921	2,568,447	723,781	60.00
65.00	06500	RESPIRATORY THERAPY	5,569	38,643	8,731	786,685	221,685	65.00
66.00	06600	PHYSICAL THERAPY	1,164	13,127	29,639	921,903	259,789	66.00
69.00	06900	ELECTROCARDIOLOGY	609	2,104	11,516	152,630	43,011	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	3,153	97,466	27,466	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	46,233	77,704	21,817	579,621	163,335	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,833	86,294	41,750	954,015	268,839	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	37	0	14,828	390,132	109,938	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,697	0	36,240	5,884,597	977,841	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	8	0	314	7,517	2,118	90.00
91.00	09100	EMERGENCY	2,689	4,770	75,835	2,686,018	756,912	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,591	0	25,444	1,571,056	442,719	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	214,777	522,299	656,291	33,914,510	6,918,599	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	6,499	1,831	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,170	0	0	98,613	27,789	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	215,947	522,299	656,291	34,019,622	6,948,219	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B Part I Date/Time Prepared: 7/21/2023 11:47 am

		Cost Center Description	OPERATION OF PLANT	RHC UTILITY EXPENSE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.00	7.01	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT	1,196,891					7.00
7.01	00701	RHC UTILITY EXPENSE	0	64,844				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	9,732	0	287,908			8.00
9.00	00900	HOUSEKEEPING	4,548	0	0	739,233		9.00
10.00	01000	DIETARY	45,726	0	0	14,117	594,325	10.00
11.00	01100	CAFETERIA	14,671	0	0	4,530	0	11.00
13.00	01300	NURSING ADMINISTRATION	12,275	1,853	0	14,359	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	21,322	0	0	6,583	0	14.00
15.00	01500	PHARMACY	20,540	0	0	6,341	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,201	0	41,068	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	298,711	0	287,908	92,221	535,303	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	198,895	0	0	61,405	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	146,909	0	0	45,356	0	54.00
60.00	06000	LABORATORY	58,588	0	0	18,088	0	60.00
65.00	06500	RESPIRATORY THERAPY	51,448	0	0	15,884	0	65.00
66.00	06600	PHYSICAL THERAPY	13,106	4,434	0	29,336	0	66.00
69.00	06900	ELECTROCARDIOLOGY	16,432	0	0	5,073	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	16,383	1,506	0	13,649	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,791	0	0	4,258	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	56,925	927	0	22,859	59,022	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	46,686	0	266,259	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	212	0	1,208	0	90.00
91.00	09100	EMERGENCY	122,897	0	0	37,942	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	60,837	0	0	3,156	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,183,736	62,819	287,908	703,692	594,325	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,155	0	0	4,061	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,025	0	31,480	0	192.00
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)	1,196,891	64,844	287,908	739,233	594,325	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B Part I | Date/Time Prepared: 7/21/2023 11:47 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	RHC UTILITY EXPENSE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	365,889					11.00
13.00	01300	NURSING ADMINISTRATION	27,841	1,365,735				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,854	25,640	269,223			14.00
15.00	01500	PHARMACY	8,502	0	0	573,372		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,258	0	0	0	996,158	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	60,373	724,378	0	0	592,922	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,008	150,529	0	0	52,706	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,218	0	0	0	12,642	54.00
60.00	06000	LABORATORY	26,768	0	0	0	31,896	60.00
65.00	06500	RESPIRATORY THERAPY	17,851	0	0	0	60,939	65.00
66.00	06600	PHYSICAL THERAPY	22,844	0	0	0	17,893	66.00
69.00	06900	ELECTROCARDIOLOGY	3,347	0	0	0	9,530	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,116	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	269,223	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,503	37,678	0	573,372	53,873	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	8,862	107,209	0	0	67,422	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	50,217	0	0	0	45,380	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	181	0	0	0	0	90.00
91.00	09100	EMERGENCY	40,991	320,301	0	0	40,453	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	40,155	0	0	0	10,502	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	365,889	1,365,735	269,223	573,372	996,158	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	365,889	1,365,735	269,223	573,372	996,158	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B Part I | Date/Time Prepared: 7/21/2023 11:47 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING RECEIVING AND STORES					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	RHC UTILITY EXPENSE					7.01
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	6,177,567	0	6,177,567		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,753,813	0	1,753,813		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,502,856	0	2,502,856		54.00
60.00	06000	LABORATORY	3,427,568	0	3,427,568		60.00
65.00	06500	RESPIRATORY THERAPY	1,154,492	0	1,154,492		65.00
66.00	06600	PHYSICAL THERAPY	1,269,305	0	1,269,305		66.00
69.00	06900	ELECTROCARDIOLOGY	230,023	0	230,023		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	157,586	0	157,586		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,012,179	0	1,012,179		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,909,329	0	1,909,329		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	823,296	0	823,296		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	7,270,980	0	7,270,980		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
90.00	09000	CLINIC	11,236	0	11,236		90.00
91.00	09100	EMERGENCY	4,005,514	0	4,005,514		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	2,128,425	0	2,128,425		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,834,169	0	33,834,169		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,546	0	25,546		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	159,907	0	159,907		192.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	34,019,622	0	34,019,622		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B Part II Date/Time Prepared: 7/21/2023 11:47 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	NEW CAP RHC REL COSTS-BLDG & FIXT	MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00560	PURCHASING RECEIVING AND STORES	0	29,618	0	28,625	58,243	5.01
5.02	00570	ADMITTING	0	10,267	0	9,923	20,190	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	5,164	0	5,164	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	616,495	14,901	595,830	1,227,226	5.04
7.00	00700	OPERATION OF PLANT	0	9,687	0	9,363	19,050	7.00
7.01	00701	RHC UTILITY EXPENSE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,807	0	4,646	9,453	8.00
9.00	00900	HOUSEKEEPING	0	2,247	0	2,171	4,418	9.00
10.00	01000	DIETARY	0	22,588	0	21,831	44,419	10.00
11.00	01100	CAFETERIA	0	7,247	0	7,005	14,252	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,064	5,164	5,860	17,088	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,533	0	10,180	20,713	14.00
15.00	01500	PHARMACY	0	10,146	0	9,806	19,952	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	20,065	0	20,065	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	147,558	0	142,612	290,170	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	98,252	0	94,958	193,210	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	72,571	0	70,139	142,710	54.00
60.00	06000	LABORATORY	0	28,942	0	27,971	56,913	60.00
65.00	06500	RESPIRATORY THERAPY	0	25,414	0	24,563	49,977	65.00
66.00	06600	PHYSICAL THERAPY	0	6,474	12,356	6,257	25,087	66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,117	0	7,845	15,962	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8,093	4,197	7,822	20,112	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,813	0	6,584	13,397	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	28,120	2,582	27,178	57,880	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	130,088	0	130,088	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	590	0	590	90.00
91.00	09100	EMERGENCY	0	60,710	0	58,675	119,385	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	30,053	0	29,045	59,098	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,250,816	195,107	1,208,889	2,654,812	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,499	0	0	6,499	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	15,381	0	15,381	192.00
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	1,257,315	210,488	1,208,889	2,676,692	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B Part II Date/Time Prepared: 7/21/2023 11:47 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	
			4.00	5.01	5.02	5.03	5.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.01	00560	PURCHASING RECEIVING AND STORES	0	58,243				5.01
5.02	00570	ADMITTING	0	97	20,287			5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	189	0	5,353		5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	2,370	0	0	1,229,596	5.04
7.00	00700	OPERATION OF PLANT	0	236	0	0	46,565	7.00
7.01	00701	RHC UTILITY EXPENSE	0	0	0	0	2,523	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,277	0	0	10,822	8.00
9.00	00900	HOUSEKEEPING	0	1,051	0	0	28,583	9.00
10.00	01000	DIETARY	0	1,905	0	0	20,794	10.00
11.00	01100	CAFETERIA	0	2,873	0	0	13,488	11.00
13.00	01300	NURSING ADMINISTRATION	0	83	0	0	50,942	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,579	0	0	8,319	14.00
15.00	01500	PHARMACY	0	91	0	0	20,930	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	120	0	0	36,167	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,129	6,066	308	139,503	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,799	1,442	364	49,614	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	617	1,606	1,507	88,692	54.00
60.00	06000	LABORATORY	0	288	2,524	983	128,083	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,502	1,501	71	39,230	65.00
66.00	06600	PHYSICAL THERAPY	0	314	510	241	45,973	66.00
69.00	06900	ELECTROCARDIOLOGY	0	164	82	94	7,611	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	26	4,860	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	12,469	3,019	177	28,905	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,992	3,352	339	47,575	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	10	0	121	19,455	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,076	0	295	173,054	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	2	0	3	375	90.00
91.00	09100	EMERGENCY	0	725	185	617	133,946	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	969	0	207	78,345	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	57,927	20,287	5,353	1,224,354	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	324	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	316	0	0	4,918	192.00
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)	0	58,243	20,287	5,353	1,229,596	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B Part II Date/Time Prepared: 7/21/2023 11:47 am

		Cost Center Description	OPERATION OF PLANT	RHC UTILITY EXPENSE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.00	7.01	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT	65,851					7.00
7.01	00701	RHC UTILITY EXPENSE	0	2,523				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	535	0	25,087			8.00
9.00	00900	HOUSEKEEPING	250	0	0	34,302		9.00
10.00	01000	DIETARY	2,516	0	0	655	70,289	10.00
11.00	01100	CAFETERIA	807	0	0	210	0	11.00
13.00	01300	NURSING ADMINISTRATION	675	72	0	666	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,173	0	0	305	0	14.00
15.00	01500	PHARMACY	1,130	0	0	294	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	280	0	1,906	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,435	0	25,087	4,279	63,309	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,943	0	0	2,849	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,083	0	0	2,105	0	54.00
60.00	06000	LABORATORY	3,223	0	0	839	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,831	0	0	737	0	65.00
66.00	06600	PHYSICAL THERAPY	721	173	0	1,361	0	66.00
69.00	06900	ELECTROCARDIOLOGY	904	0	0	235	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	901	59	0	633	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	759	0	0	198	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,132	36	0	1,061	6,980	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,816	0	12,357	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	8	0	56	0	90.00
91.00	09100	EMERGENCY	6,762	0	0	1,761	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,347	0	0	146	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	65,127	2,444	25,087	32,653	70,289	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	724	0	0	188	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	79	0	1,461	0	192.00
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)	65,851	2,523	25,087	34,302	70,289	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B Part II | Date/Time Prepared: 7/21/2023 11:47 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	RHC UTILITY EXPENSE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	31,630					11.00
13.00	01300	NURSING ADMINISTRATION	2,406	71,932				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	160	1,350	33,599			14.00
15.00	01500	PHARMACY	735	0	0	43,132		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,578	0	0	0	60,116	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,223	38,153	0	0	35,780	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,297	7,928	0	0	3,181	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,575	0	0	0	763	54.00
60.00	06000	LABORATORY	2,314	0	0	0	1,925	60.00
65.00	06500	RESPIRATORY THERAPY	1,543	0	0	0	3,678	65.00
66.00	06600	PHYSICAL THERAPY	1,975	0	0	0	1,080	66.00
69.00	06900	ELECTROCARDIOLOGY	289	0	0	0	575	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	96	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	33,599	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	303	1,984	0	43,132	3,251	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	766	5,647	0	0	4,069	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,340	0	0	0	2,739	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	16	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,543	16,870	0	0	2,441	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,471	0	0	0	634	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,630	71,932	33,599	43,132	60,116	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	31,630	71,932	33,599	43,132	60,116	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B Part II | Date/Time Prepared: 7/21/2023 11:47 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING RECEIVING AND STORES					5.01
5.02	00570	ADMITTING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	RHC UTILITY EXPENSE					7.01
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	625,442	0	625,442		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	272,627	0	272,627		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	247,658	0	247,658		54.00
60.00	06000	LABORATORY	197,092	0	197,092		60.00
65.00	06500	RESPIRATORY THERAPY	101,070	0	101,070		65.00
66.00	06600	PHYSICAL THERAPY	77,435	0	77,435		66.00
69.00	06900	ELECTROCARDIOLOGY	25,916	0	25,916		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,687	0	26,687		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,169	0	78,169		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	135,282	0	135,282		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	99,157	0	99,157		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	326,765	0	326,765		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
90.00	09000	CLINIC	1,050	0	1,050		90.00
91.00	09100	EMERGENCY	286,235	0	286,235		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	146,217	0	146,217		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,646,802	0	2,646,802		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,735	0	7,735		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,155	0	22,155		192.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,676,692	0	2,676,692		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B-1 | Date/Time Prepared: 7/21/2023 11:47 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW CAP RHC REL COSTS-BLDG & FIXT (CLINIC SQ FT)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	
			1.00	1.01	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	52,045					1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT	0	28,534				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			51,776			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	13,586,363		4.00
5.01	00560	PURCHASING RECEIVING AND STORES	1,226	0	1,226	114,883	2,026,528	5.01
5.02	00570	ADMITTING	425	0	425	313,447	3,384	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	700	0	368,416	6,591	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	25,519	2,020	25,519	405,357	82,447	5.04
7.00	00700	OPERATION OF PLANT	401	0	401	289,550	8,211	7.00
7.01	00701	RHC UTILITY EXPENSE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	199	0	199	30,289	148,816	8.00
9.00	00900	HOUSEKEEPING	93	0	93	390,213	36,562	9.00
10.00	01000	DIETARY	935	0	935	213,869	66,290	10.00
11.00	01100	CAFETERIA	300	0	300	206,272	99,975	11.00
13.00	01300	NURSING ADMINISTRATION	251	700	251	718,969	2,883	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	436	0	436	47,868	54,937	14.00
15.00	01500	PHARMACY	420	0	420	219,547	3,150	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,720	0	471,501	4,169	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,108	0	6,108	1,559,169	39,289	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,067	0	4,067	387,586	62,588	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,004	0	3,004	470,477	21,466	54.00
60.00	06000	LABORATORY	1,198	0	1,198	691,278	10,024	60.00
65.00	06500	RESPIRATORY THERAPY	1,052	0	1,052	460,981	52,265	65.00
66.00	06600	PHYSICAL THERAPY	268	1,675	268	589,932	10,921	66.00
69.00	06900	ELECTROCARDIOLOGY	336	0	336	86,434	5,716	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	335	569	335	28,811	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	433,867	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	282	0	282	90,466	730,408	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,164	350	1,164	228,862	343	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	17,635	0	3,064,504	72,232	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	80	0	4,670	78	90.00
91.00	09100	EMERGENCY	2,513	0	2,513	1,058,577	25,236	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,244	0	1,244	1,036,977	33,699	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,776	26,449	51,776	13,548,905	2,015,547	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	269	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,085	0	37,458	10,981	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,257,315	210,488	1,208,889	4,640,422	215,947	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.158228	7.376744	23.348443	0.341550	0.106560	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0	58,243	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000	0.028740	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

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		Cost Center Description	ADMITTING (INPATIENT CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.02	5.03	5A.04	5.04	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00570	ADMITTING	10,730,207					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	93,603,906				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	0	-6,948,219	24,656,788		5.04
7.00	00700	OPERATION OF PLANT	0	0	0	933,760	24,474	7.00
7.01	00701	RHC UTILITY EXPENSE	0	0	0	50,588	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	217,020	199	8.00
9.00	00900	HOUSEKEEPING	0	0	0	573,168	93	9.00
10.00	01000	DIETARY	0	0	0	416,979	935	10.00
11.00	01100	CAFETERIA	0	0	0	270,470	300	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,021,540	251	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	166,816	436	14.00
15.00	01500	PHARMACY	0	0	0	419,715	420	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	725,256	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,209,804	5,397,283	0	2,797,441	6,108	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	762,506	6,382,019	0	994,908	4,067	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	849,364	26,170,978	0	1,778,543	3,004	54.00
60.00	06000	LABORATORY	1,334,569	17,247,344	0	2,568,447	1,198	60.00
65.00	06500	RESPIRATORY THERAPY	793,877	1,245,392	0	786,685	1,052	65.00
66.00	06600	PHYSICAL THERAPY	269,672	4,227,458	0	921,903	268	66.00
69.00	06900	ELECTROCARDIOLOGY	43,230	1,642,608	0	152,630	336	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	449,728	0	97,466	335	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,596,357	3,111,799	0	579,621	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,772,832	5,954,873	0	954,015	282	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	2,114,953	0	390,132	1,164	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,169,058	-2,414,615	3,469,982	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	44,801	0	7,517	0	90.00
91.00	09100	EMERGENCY	97,996	10,816,527	0	2,686,018	2,513	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,629,085	0	1,571,056	1,244	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,730,207	93,603,906	-9,362,834	24,551,676	24,205	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	6,499	269	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	98,613	0	192.00
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)	522,299	656,291		6,948,219	1,196,891	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.048676	0.007011		0.281797	48.904593	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	20,287	5,353		1,229,596	65,851	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001891	0.000057		0.049868	2.690651	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: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B-1 | Date/Time Prepared: 7/21/2023 11:47 am

		Cost Center Description	RHC UTILITY EXPENSE (CLINIC SQ FT)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAY)	CAFETERIA (GROSS SALARIES)	
			7.01	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	RHC UTILITY EXPENSE	24,494					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,086				8.00
9.00	00900	HOUSEKEEPING	0	0	48,961			9.00
10.00	01000	DIETARY	0	0	935	2,316		10.00
11.00	01100	CAFETERIA	0	0	300	0	9,448,923	11.00
13.00	01300	NURSING ADMINISTRATION	700	0	951	0	718,969	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	436	0	47,868	14.00
15.00	01500	PHARMACY	0	0	420	0	219,547	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,720	0	2,720	0	471,501	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,086	6,108	2,086	1,559,169	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	4,067	0	387,586	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,004	0	470,477	54.00
60.00	06000	LABORATORY	0	0	1,198	0	691,278	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,052	0	460,981	65.00
66.00	06600	PHYSICAL THERAPY	1,675	0	1,943	0	589,932	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	336	0	86,434	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	569	0	904	0	28,811	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	282	0	90,466	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	350	0	1,514	230	228,862	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	17,635	0	17,635	0	1,296,818	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	80	0	80	0	4,670	90.00
91.00	09100	EMERGENCY	0	0	2,513	0	1,058,577	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	209	0	1,036,977	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,729	2,086	46,607	2,316	9,448,923	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	269	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	765	0	2,085	0	0	192.00
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)	64,844	287,908	739,233	594,325	365,889	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.647342	138.019175	15.098405	256.617012	0.038723	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,523	25,087	34,302	70,289	31,630	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.103005	12.026366	0.700598	30.349309	0.003347	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: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B-1 | Date/Time Prepared: 7/21/2023 11:47 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING RECEIVING AND STORES						5.01
5.02	00570	ADMITTING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	RHC UTILITY EXPENSE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	97,797					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,836	433,867				14.00
15.00	01500	PHARMACY	0	0	602,353			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	15,366		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,871	0	0	9,146		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,779	0	0	813		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	195		54.00
60.00	06000	LABORATORY	0	0	0	492		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	940		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	276		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	147		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	433,867	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,698	0	602,353	831		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	7,677	0	0	1,040		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	700		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0		88.02
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	22,936	0	0	624		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	162		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	97,797	433,867	602,353	15,366		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,365,735	269,223	573,372	996,158		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.964999	0.620520	0.951887	64.828713		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	71,932	33,599	43,132	60,116		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.735524	0.077441	0.071606	3.912274		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet C Part I Date/Time Prepared: 7/21/2023 11:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,177,567		6,177,567	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,753,813		1,753,813	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,502,856		2,502,856	0	0	54.00
60.00	06000	LABORATORY	3,427,568		3,427,568	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,154,492	0	1,154,492	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,269,305	0	1,269,305	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	230,023		230,023	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	157,586		157,586	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,012,179		1,012,179	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,909,329		1,909,329	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	823,296		823,296	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,270,980		7,270,980	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0		0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0		0	0	0	88.02
90.00	09000	CLINIC	11,236		11,236	0	0	90.00
91.00	09100	EMERGENCY	4,005,514		4,005,514	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,112,542		1,112,542		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,128,425		2,128,425	0	0	95.00
200.00		Subtotal (see instructions)	34,946,711	0	34,946,711	0	0	200.00
201.00		Less Observation Beds	1,112,542		1,112,542		0	201.00
202.00		Total (see instructions)	33,834,169	0	33,834,169	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet C Part I Date/Time Prepared: 7/21/2023 11:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,208,643		3,208,643			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	762,506	5,619,513	6,382,019	0.274805	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	849,364	25,321,614	26,170,978	0.095635	0.000000	54.00
60.00	06000	LABORATORY	1,334,569	15,912,775	17,247,344	0.198730	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	793,877	451,515	1,245,392	0.927011	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	269,672	3,957,786	4,227,458	0.300253	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	43,230	1,599,378	1,642,608	0.140035	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	449,728	449,728	0.350403	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,596,357	1,515,442	3,111,799	0.325271	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,772,832	4,182,041	5,954,873	0.320633	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	2,114,953	2,114,953	0.389274	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,169,058	5,169,058			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0			88.02
90.00	09000	CLINIC	0	44,801	44,801	0.250798	0.000000	90.00
91.00	09100	EMERGENCY	97,996	10,718,531	10,816,527	0.370314	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,161	2,187,479	2,188,640	0.508326	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,629,085	3,629,085	0.586491	0.000000	95.00
200.00		Subtotal (see instructions)	10,730,207	82,873,699	93,603,906			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,730,207	82,873,699	93,603,906			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet C Part I Date/Time Prepared: 7/21/2023 11:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
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: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet C Part I Date/Time Prepared: 7/21/2023 11:47 am

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	6,177,567		6,177,567	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,753,813		1,753,813	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,502,856		2,502,856	0	0	54.00
60.00	06000	LABORATORY	3,427,568		3,427,568	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,154,492	0	1,154,492	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,269,305	0	1,269,305	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	230,023		230,023	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	157,586		157,586	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,012,179		1,012,179	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,909,329		1,909,329	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	823,296		823,296	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,270,980		7,270,980	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0		0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0		0	0	0	88.02
90.00	09000	CLINIC	11,236		11,236	0	0	90.00
91.00	09100	EMERGENCY	4,005,514		4,005,514	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,112,542		1,112,542		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,128,425		2,128,425	0	0	95.00
200.00		Subtotal (see instructions)	34,946,711	0	34,946,711	0	0	200.00
201.00		Less Observation Beds	1,112,542		1,112,542		0	201.00
202.00		Total (see instructions)	33,834,169	0	33,834,169	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet C Part I Date/Time Prepared: 7/21/2023 11:47 am

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	3,208,643		3,208,643			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	762,506	5,619,513	6,382,019	0.274805	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	849,364	25,321,614	26,170,978	0.095635	0.000000	54.00
60.00	06000	LABORATORY	1,334,569	15,912,775	17,247,344	0.198730	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	793,877	451,515	1,245,392	0.927011	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	269,672	3,957,786	4,227,458	0.300253	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	43,230	1,599,378	1,642,608	0.140035	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	449,728	449,728	0.350403	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,596,357	1,515,442	3,111,799	0.325271	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,772,832	4,182,041	5,954,873	0.320633	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	2,114,953	2,114,953	0.389274	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,169,058	5,169,058	1.406635	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0.000000	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0.000000	0.000000	88.02
90.00	09000	CLINIC	0	44,801	44,801	0.250798	0.000000	90.00
91.00	09100	EMERGENCY	97,996	10,718,531	10,816,527	0.370314	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,161	2,187,479	2,188,640	0.508326	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,629,085	3,629,085	0.586491	0.000000	95.00
200.00		Subtotal (see instructions)	10,730,207	82,873,699	93,603,906			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,730,207	82,873,699	93,603,906			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet C Part I Date/Time Prepared: 7/21/2023 11:47 am

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
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
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: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part II Date/Time Prepared: 7/21/2023 11:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	272,627	6,382,019	0.042718	583,958	24,946	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	247,658	26,170,978	0.009463	383,182	3,626	54.00
60.00	06000	LABORATORY	197,092	17,247,344	0.011427	851,162	9,726	60.00
65.00	06500	RESPIRATORY THERAPY	101,070	1,245,392	0.081155	578,485	46,947	65.00
66.00	06600	PHYSICAL THERAPY	77,435	4,227,458	0.018317	66,814	1,224	66.00
69.00	06900	ELECTROCARDIOLOGY	25,916	1,642,608	0.015777	18,425	291	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,687	449,728	0.059340	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,169	3,111,799	0.025120	1,130,964	28,410	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	135,282	5,954,873	0.022718	1,221,344	27,746	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	99,157	2,114,953	0.046884	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	326,765	5,169,058	0.063216	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0.000000	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0.000000	0	0	88.02
90.00	09000	CLINIC	1,050	44,801	0.023437	0	0	90.00
91.00	09100	EMERGENCY	286,235	10,816,527	0.026463	4,227	112	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	112,638	2,188,640	0.051465	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,987,781	86,766,178		4,838,561	143,028	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part IV Date/Time Prepared: 7/21/2023 11:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part IV | Date/Time Prepared: 7/21/2023 11:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	6,382,019	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	26,170,978	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	17,247,344	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,245,392	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,227,458	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,642,608	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	449,728	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,111,799	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,954,873	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	2,114,953	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,169,058	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0.000000	88.02
90.00	09000	CLINIC	0	0	0	44,801	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	10,816,527	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,188,640	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	86,766,178		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part IV | Date/Time Prepared: 7/21/2023 11:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	583,958	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	383,182	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	851,162	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	578,485	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66,814	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	18,425	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,130,964	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,221,344	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	4,227	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		4,838,561	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part V Date/Time Prepared: 7/21/2023 11:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.274805	0	2,471,992	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.095635	0	10,816,846	0	0	54.00
60.00	06000	LABORATORY	0.198730	0	6,581,494	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.927011	0	222,326	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.300253	0	1,430,246	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.140035	0	763,345	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.350403	0	186,907	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.325271	0	789,696	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.320633	0	2,761,609	24,559	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.389274	0	1,823,982	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
90.00	09000	CLINIC	0.250798	0	19,645	0	0	90.00
91.00	09100	EMERGENCY	0.370314	0	3,678,165	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.508326	0	241,645	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.586491		0			95.00
200.00		Subtotal (see instructions)		0	31,787,898	24,559	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	31,787,898	24,559	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part V Date/Time Prepared: 7/21/2023 11:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	679,316	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,034,469	0		54.00
60.00	06000	LABORATORY	1,307,940	0		60.00
65.00	06500	RESPIRATORY THERAPY	206,099	0		65.00
66.00	06600	PHYSICAL THERAPY	429,436	0		66.00
69.00	06900	ELECTROCARDIOLOGY	106,895	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	65,493	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	256,865	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	885,463	7,874		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	710,029	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
90.00	09000	CLINIC	4,927	0		90.00
91.00	09100	EMERGENCY	1,362,076	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	122,834	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	7,171,842	7,874		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,171,842	7,874		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part I Date/Time Prepared: 7/21/2023 11:47 am

Title XIX | Hospital | Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	625,442	91,747	533,695	2,089	255.48	30.00
200.00	Total (lines 30 through 199)	625,442		533,695	2,089		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	11	2,810	30.00
200.00	Total (lines 30 through 199)	11	2,810	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part II Date/Time Prepared: 7/21/2023 11:47 am

Title XIX | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	272,627	6,382,019	0.042718	12,084	516	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	247,658	26,170,978	0.009463	16,411	155	54.00
60.00	06000	LABORATORY	197,092	17,247,344	0.011427	8,506	97	60.00
65.00	06500	RESPIRATORY THERAPY	101,070	1,245,392	0.081155	0	0	65.00
66.00	06600	PHYSICAL THERAPY	77,435	4,227,458	0.018317	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	25,916	1,642,608	0.015777	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,687	449,728	0.059340	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,169	3,111,799	0.025120	5,319	134	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	135,282	5,954,873	0.022718	8,349	190	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	99,157	2,114,953	0.046884	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	326,765	5,169,058	0.063216	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0.000000	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0.000000	0	0	88.02
90.00	09000	CLINIC	1,050	44,801	0.023437	0	0	90.00
91.00	09100	EMERGENCY	286,235	10,816,527	0.026463	1,088	29	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	112,638	2,188,640	0.051465	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,987,781	86,766,178		51,757	1,121	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part III Date/Time Prepared: 7/21/2023 11:47 am

Title XIX | Hospital | Cost

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,089	0.00	11	30.00
200.00		Total (lines 30 through 199)		0	2,089		11	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part IV Date/Time Prepared: 7/21/2023 11:47 am

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part IV Date/Time Prepared: 7/21/2023 11:47 am

Title XIX | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	6,382,019	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	26,170,978	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	17,247,344	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,245,392	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,227,458	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,642,608	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	449,728	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,111,799	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,954,873	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	2,114,953	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,169,058	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0.000000	88.02
90.00	09000	CLINIC	0	0	0	44,801	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	10,816,527	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,188,640	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	86,766,178		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part IV | Date/Time Prepared: 7/21/2023 11:47 am

Title XIX | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	12,084	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	16,411	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	8,506	0	0	0	60.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	5,319	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	8,349	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	1,088	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		51,757	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part V Date/Time Prepared: 7/21/2023 11:47 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.274805	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.095635	0	0	0	0	54.00
60.00	06000	LABORATORY	0.198730	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.927011	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.300253	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.140035	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.350403	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.325271	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.320633	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.389274	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
90.00	09000	CLINIC	0.250798	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.370314	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.508326	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.586491	0	0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part V Date/Time Prepared: 7/21/2023 11:47 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D-1 | Date/Time Prepared: 7/21/2023 11:47 am

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,527	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,089	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,648	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	292	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)	62	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	70	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)	14	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,231	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)	287	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)	57	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	170.71	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	177.54	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,177,567	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)	11,950	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)	2,486	25.00
26.00	Total swing-bed cost (see instructions)	907,497	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,270,070	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,270,070	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,522.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,105,530	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)	3,105,530	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D-1 | Date/Time Prepared: 7/21/2023 11:47 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,686,213	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)	4,791,743	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)	724,035	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	143,798	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	867,833	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)	441	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,522.77	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,112,542	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D-1 | Date/Time Prepared: 7/21/2023 11:47 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	625,442	6,177,567	0.101244	1,112,542	112,638	90.00
91.00	Nursing Program cost	0	6,177,567	0.000000	1,112,542	0	91.00
92.00	Allied health cost	0	6,177,567	0.000000	1,112,542	0	92.00
93.00	All other Medical Education	0	6,177,567	0.000000	1,112,542	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D-1 | Date/Time Prepared: 7/21/2023 11:47 am

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)	2,527	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,089	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,648	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	233	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)	121	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	17	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)	67	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	11	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	147.50	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.42	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,177,567	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)	2,508	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)	10,413	25.00
26.00	Total swing-bed cost (see instructions)	906,201	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,271,366	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,271,366	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,523.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	27,757	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)	27,757	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D-1 | Date/Time Prepared: 7/21/2023 11:47 am

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)	11,390	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)	39,147	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)	441	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,523.39	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,112,815	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D-1 | Date/Time Prepared: 7/21/2023 11:47 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	625,442	6,177,567	0.101244	1,112,815	112,666	90.00
91.00	Nursing Program cost	0	6,177,567	0.000000	1,112,815	0	91.00
92.00	Allied health cost	0	6,177,567	0.000000	1,112,815	0	92.00
93.00	All other Medical Education	0	6,177,567	0.000000	1,112,815	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D-3 | Date/Time Prepared: 7/21/2023 11:47 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,619,117		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.274805	583,958	160,475	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.095635	383,182	36,646	54.00
60.00	06000	LABORATORY	0.198730	851,162	169,151	60.00
65.00	06500	RESPIRATORY THERAPY	0.927011	578,485	536,262	65.00
66.00	06600	PHYSICAL THERAPY	0.300253	66,814	20,061	66.00
69.00	06900	ELECTROCARDIOLOGY	0.140035	18,425	2,580	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.350403	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.325271	1,130,964	367,870	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.320633	1,221,344	391,603	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.389274	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	0.250798	0	0	90.00
91.00	09100	EMERGENCY	0.370314	4,227	1,565	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.508326	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,838,561	1,686,213	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,838,561		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1351 | Component CCN: 14-Z351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D-3 | Date/Time Prepared: 7/21/2023 11:47 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.274805	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.095635	7,347	703	54.00
60.00	06000	LABORATORY	0.198730	82,466	16,388	60.00
65.00	06500	RESPIRATORY THERAPY	0.927011	60,161	55,770	65.00
66.00	06600	PHYSICAL THERAPY	0.300253	153,588	46,115	66.00
69.00	06900	ELECTROCARDIOLOGY	0.140035	2,345	328	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.350403	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.325271	126,438	41,127	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.320633	149,836	48,042	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.389274	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	0.250798	0	0	90.00
91.00	09100	EMERGENCY	0.370314	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.508326	625	318	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		582,806	208,791	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)		582,806		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D-3 | Date/Time Prepared: 7/21/2023 11:47 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		13,822		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.274805	12,084	3,321	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.095635	16,411	1,569	54.00
60.00	06000	LABORATORY	0.198730	8,506	1,690	60.00
65.00	06500	RESPIRATORY THERAPY	0.927011	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.300253	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.140035	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.350403	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.325271	5,319	1,730	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.320633	8,349	2,677	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.389274	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.406635	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	88.02
90.00	09000	CLINIC	0.250798	0	0	90.00
91.00	09100	EMERGENCY	0.370314	1,088	403	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.508326	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		51,757	11,390	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)		51,757		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet E Part B Date/Time Prepared: 7/21/2023 11:47 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,179,716	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)	7,179,716	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)	7,251,513	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)	58,289	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,856,237	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,336,987	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)	2,336,987	30.00
31.00	Primary payer payments	1,758	31.00
32.00	Subtotal (line 30 minus line 31)	2,335,229	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)	796,321	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	517,609	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	347,553	36.00
37.00	Subtotal (see instructions)	2,852,838	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	ILLING ADJUSTMENT	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)	2,852,838	40.00
40.01	Sequestration adjustment (see instructions)	45,075	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		40.03
41.00	Interim payments	2,646,301	41.00
41.01	Interim payments-PARHM or CHART		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	161,462	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: 14-1351	Period: From 03/01/2022 To 02/28/2023	Worksheet E Part B Date/Time Prepared: 7/21/2023 11:47 am
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet E-1 Part I | Date/Time Prepared: 7/21/2023 11:47 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,391,496		2,912,900	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	08/30/2022	45,608		0	3.01
3.02		09/30/2022	87,778		0	3.02
3.03		01/30/2023	494,186		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	08/30/2022	224,993	3.50
3.51			0	01/30/2023	41,606	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)		627,572		-266,599	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)		4,019,068		2,646,301	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		519,590		161,462	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,538,658		2,807,763	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1351 | Component CCN: 14-Z351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet E-1 Part I | Date/Time Prepared: 7/21/2023 11:47 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		986,234		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	08/30/2022	34,681		0	3.01
3.02		01/30/2023	16,826		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)		51,507		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,037,741		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		29,597		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,067,338		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1351	Period: From 03/01/2022 To 02/28/2023	Worksheet E-1 Part II Date/Time Prepared: 7/21/2023 11:47 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1351 | Component CCN: 14-Z351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet E-2 | Date/Time Prepared: 7/21/2023 11:47 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	876,511	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)	210,879	0	3.00
3.01	Nursing and allied health payment-PARHM or CHART (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	344	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,087,390	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,087,390	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,087,390	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,918	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,084,472	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,084,472	0	19.00
19.01	Sequestration adjustment (see instructions)	17,134	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM or CHART pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	1,037,741	0	20.00
20.01	Interim payments-PARHM or CHART			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM or CHART (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)	29,597	0	22.00
22.01	Balance due provider/program-PARHM or CHART (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: 14-1351	Period: From 03/01/2022 To 02/28/2023	Worksheet E-3 Part V Date/Time Prepared: 7/21/2023 11:47 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,791,743	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)	4,791,743	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,839,660	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)	4,839,660	19.00
20.00	Deductibles (exclude professional component)	289,268	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,550,392	22.00
23.00	Coinsurance	2,723	23.00
24.00	Subtotal (line 22 minus line 23)	4,547,669	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	98,232	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	63,851	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	89,826	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,611,520	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)	4,611,520	30.00
30.01	Sequestration adjustment (see instructions)	72,862	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM or CHART		30.03
31.00	Interim payments	4,019,068	31.00
31.01	Interim payments-PARHM or CHART		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM or CHART (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	519,590	33.00
33.01	Balance due provider/program-PARHM or CHART (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: 14-1351	Period: From 03/01/2022 To 02/28/2023	Worksheet E-3 Part VII Date/Time Prepared: 7/21/2023 11:47 am
	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	39,147		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)	39,147	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)	39,147	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	13,822		8.00
9.00	Ancillary service charges	51,757	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)	65,579	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)	65,579	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	26,432	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)	39,147	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)	39,147	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)	39,147	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)	39,147	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	39,147	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)	39,147	0	40.00
41.00	Interim payments	7,875	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	31,272	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: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet G | Date/Time Prepared: 7/21/2023 11:47 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	8,739,685	0	0	0	1.00
2.00	Temporary investments	390,534	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	13,483,387	0	0	0	4.00
5.00	Other receivable	270,360	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,978,431	0	0	0	6.00
7.00	Inventory	242,851	0	0	0	7.00
8.00	Prepaid expenses	188,638	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13,337,024	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	135,111	0	0	0	12.00
13.00	Land improvements	351,667	0	0	0	13.00
14.00	Accumulated depreciation	-897,662	0	0	0	14.00
15.00	Buildings	15,187,858	0	0	0	15.00
16.00	Accumulated depreciation	-11,529,870	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	15,316,107	0	0	0	23.00
24.00	Accumulated depreciation	-11,795,463	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	1,573,806	0	0	0	27.00
28.00	Accumulated depreciation	-1,573,806	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	6,767,748	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	23,974,101	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	12,247,906	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	36,222,007	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	56,326,779	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,256,891	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,784,822	0	0	0	38.00
39.00	Payroll taxes payable	205,844	0	0	0	39.00
40.00	Notes and loans payable (short term)	84,269	0	0	0	40.00
41.00	Deferred income	30,438	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	1,038,263	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,400,527	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	456,791	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	6,978,647	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,435,438	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,835,965	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	44,490,814				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)	44,490,814	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	56,326,779	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet G-1 | Date/Time Prepared: 7/21/2023 11:47 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		36,065,138		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		8,425,678				2.00
3.00	Total (sum of line 1 and line 2)		44,490,816		0		3.00
4.00	ROUNDING	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		44,490,816		0		11.00
12.00	ROUNDING	2		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		2		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		44,490,814		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	ROUNDING		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	ROUNDING		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 7/21/2023 11:47 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,780,796		2,780,796	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	196,930		196,930	5.00
6.00	Swing bed - NF	53,814		53,814	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)	3,031,540		3,031,540	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)	3,031,540		3,031,540	17.00
18.00	Ancillary services	7,412,919	73,238,242	80,651,161	18.00
19.00	Outpatient services	0	2,114,953	2,114,953	19.00
20.00	RURAL HEALTH CLINIC	0	3,148,731	3,148,731	20.00
20.01	RURAL HEALTH CLINIC II	0	963,760	963,760	20.01
20.02	RURAL HEALTH CLINIC III	0	3,795,376	3,795,376	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	3,629,085	3,629,085	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,444,459	86,890,147	97,334,606	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		32,713,493		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		32,713,493		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1351 | Period: From 03/01/2022 To 02/28/2023 | Worksheet G-3 | Date/Time Prepared: 7/21/2023 11:47 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	97,334,606	1.00
2.00	Less contractual allowances and discounts on patients' accounts	59,086,682	2.00
3.00	Net patient revenues (line 1 minus line 2)	38,247,924	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32,713,493	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,534,431	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	254,548	6.00
7.00	Income from investments	308,590	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	5,000	10.00
11.00	Rebates and refunds of expenses	12,001	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	132,889	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	543	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	10,508	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	3,514	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	444	21.00
22.00	Rental of hospital space	59,452	22.00
23.00	Governmental appropriations	100,115	23.00
24.00	FLORA CLINIC OTHER REVENUE	2,500	24.00
24.01	REINSURANCE REFUNDS	677,769	24.01
24.02	MISCELLANEOUS INCOME	11,246	24.02
24.03	GRANT INCOME	87,997	24.03
24.04	EMERGENCY GRANT REVENUE	14,386	24.04
24.05	340B DRUG REVENUE	418,425	24.05
24.06	SALE OF EQUIPMENT	3,456	24.06
24.07	DISASTER PREPARDNESS INCOME	3,696	24.07
24.08	CLAY CITY OTHER INCOME	3,764	24.08
24.09	REVENUE INTEGRITY REVENUE	11,817	24.09
24.10	PHYSICAL AND OCCUPATIONAL OTHER REV	9,823	24.10
24.11	PUBLIC RELATION OTHER REVENUE	5,865	24.11
24.12	DATA PROCESSING REVENUE	54,427	24.12
24.13	MEDICAL SURGICAL OTHER INCOME	8,636	24.13
24.14	PHYSICIAN FEE REVENUE	1,000	24.14
24.15	SALE OF SCRAP	226	24.15
24.16	RHC MEDICAL DIRECTOR REIMBURSEMENT	3,789	24.16
24.17	RHC BEHAVIORAL HEALTH INCOME	125,108	24.17
24.18	QUALITY INCOME	2,735	24.18
24.50	COVID-19 PHE Funding	556,978	24.50
25.00	Total other income (sum of lines 6-24)	2,891,247	25.00
26.00	Total (line 5 plus line 25)	8,425,678	26.00
27.00	CASH SHORT	0	27.00
27.01	LOSS ON INVESTMENTS	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)	8,425,678	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1351 | Component CCN: 14-3458 | Period: From 03/01/2022 To 02/28/2023 | Worksheet M-1 | Date/Time Prepared: 7/21/2023 11:47 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,278,295	0	1,278,295	136,975	1,415,270	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	973,784	0	973,784	-130,584	843,200	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	820,338	0	820,338	0	820,338	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	80,892	42,000	122,892	-240	122,652	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	1,194,160	0	1,194,160	-4,670	1,189,490	9.00
10.00	Subtotal (sum of lines 1 through 9)	4,347,469	42,000	4,389,469	1,481	4,390,950	10.00
11.00	Physician Services Under Agreement	0	35,550	35,550	-35,550	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	74,292	74,292	0	74,292	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	109,842	109,842	-35,550	74,292	14.00
15.00	Medical Supplies	0	30,431	30,431	0	30,431	15.00
16.00	Transportation (Health Care Staff)	0	13,840	13,840	0	13,840	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	55,344	55,344	0	55,344	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	99,615	99,615	0	99,615	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	4,347,469	251,457	4,598,926	-34,069	4,564,857	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	159,841	159,841	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	159,841	159,841	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	35,213	35,213	0	35,213	29.00
30.00	Administrative Costs	0	30,272	30,272	-1,620	28,652	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	65,485	65,485	-1,620	63,865	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,347,469	316,942	4,664,411	124,152	4,788,563	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1351 | Component CCN: 14-3458 | Period: From 03/01/2022 To 02/28/2023 | Worksheet M-1 | Date/Time Prepared: 7/21/2023 11:47 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-3,696	1,411,574		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	843,200		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	820,338		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	-117,214	5,438		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	1,189,490		9.00
10.00	Subtotal (sum of lines 1 through 9)	-120,910	4,270,040		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	74,292		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	74,292		14.00
15.00	Medical Supplies	0	30,431		15.00
16.00	Transportation (Health Care Staff)	0	13,840		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	55,344		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	99,615		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-120,910	4,443,947		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	159,841		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	159,841		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	35,213		29.00
30.00	Administrative Costs	-3,764	24,888		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-3,764	60,101		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-124,674	4,663,889		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1351 | Component CCN: 14-3458 | Period: From 03/01/2022 To 02/28/2023 | Worksheet M-2 | Date/Time Prepared: 7/21/2023 11:47 am

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC I Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.02	9,184	4,200	8,484		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.90	16,655	2,100	6,090		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.92	25,839		14,574	25,839	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	1.10	3,359			3,359	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)	6.02	29,198			29,198	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)					4,443,947	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					159,841	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					4,603,788	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.965281	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					60,101	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,607,091	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,667,192	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,667,192	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,574,590	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					7,018,537	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1351 Component CCN: 14-3458	Period: From 03/01/2022 To 02/28/2023	Worksheet M-3 Date/Time Prepared: 7/21/2023 11:47 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			7,018,537	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			11,954	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			7,006,583	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			29,198	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)			29,198	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			239.97	7.00
		Calculation of Limit (1)			
		Rate Period 1 (03/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 02/28/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	264.87	275.46		8.00
9.00	Rate for Program covered visits (see instructions)	239.97	239.97		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	4,986	1,111		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	1,196,490	266,607		11.00
12.00	Program covered visits for mental health services (from contractor records)	1,119	260		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	268,526	62,392		13.00
14.00	Limit adjustment for mental health services (see instructions)	268,526	62,392		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	1,794,015		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,676,128		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		90,596		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		96,968		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.)		1,258,175		16.04
16.05	Total program cost (see instructions)	0	1,355,143		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		124,328		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		292,157		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,355,143		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,139		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,360,282		22.00
23.00	Allowable bad debts (see instructions)		129,791		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		84,364		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		119,220		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)		1,444,646		26.00
26.01	Sequestration adjustment (see instructions)		22,826		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		1,136,729		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)		285,091		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: 14-1351 | Component CCN: 14-3458 | Period: From 03/01/2022 To 02/28/2023 | Worksheet M-4 | Date/Time Prepared: 7/21/2023 11:47 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	4,270,040	4,270,040	4,270,040	4,270,040	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000042	0.000530	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	179	2,263	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,688	3,440	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,867	5,703	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	4,443,947	4,443,947	4,443,947	4,443,947	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,574,590	2,574,590	2,574,590	2,574,590	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000420	0.001283	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1,081	3,303	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	2,948	9,006	0	0	10.00
11.00	Total number of injections/infusions (from your records)	17	215	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	173.41	41.89	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	12	73	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	2,081	3,058	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)		11,954	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		5,139	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1351 Component CCN: 14-3458	Period: From 03/01/2022 To 02/28/2023	Worksheet M-5 Date/Time Prepared: 7/21/2023 11:47 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,136,729	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)		1,136,729	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		285,091	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,421,820	7.00

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