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: 14-1324	Period: From 04/01/2022 To 03/31/2023	Worksheet S Parts I-III Date/Time Prepared: 8/31/2023 4:04 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 8/31/2023 Time: 4:04 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FERRELL HOSPITAL (14-1324) for the cost reporting period beginning 04/01/2022 and ending 03/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Anthony Keene		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Anthony Keene			2
3	Signatory Title	CHIEF EXECUTIVE OFFICER			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-74,568	-887,537	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	635,240	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		322,886		0	10.00
10.01	RURAL HEALTH CLINIC II	0		179,545		0	10.01
10.02	RURAL HEALTH CLINIC III	0		31,551		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		44,911		0	10.03
200.00	TOTAL	0	560,672	-308,644	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 8/31/2023 4:04 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1201 PINE STREET	PO Box:			1.00
2.00	City: EL DORADO	State: IL	Zip Code: 62930	County: SALINE	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	FERRELL HOSPITAL	141324	99914	1	02/01/2003	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	FERRELL SWINGBED SNF	14Z324	99914		02/01/2003	N	O	O	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	FERRELL HOSPITAL CLINIC	148506	99914		04/01/2009	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	CARMI CLINIC	148588	99914		05/23/2018	N	O	O	15.01
15.02	Hospital-Based Health Clinic - RHC III	MCLEANSBORO FAMILY MEDICINE	148616	99914		03/26/2020	N	O	O	15.02
15.03	Hospital-Based Health Clinic - RHC IV	HARRISBURG FAMILY MEDICINE	148627	99914		12/07/2021	N	O	O	15.03
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	04/01/2022	03/31/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N			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.	1	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 8/31/2023 4:04 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1324	Period: From 04/01/2022 To 03/31/2023	Worksheet S-2 Part I Date/Time Prepared: 8/31/2023 4:04 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 8/31/2023 4:04 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 8/31/2023 4:04 pm

					1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)					
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?				N	68.00
			1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
					1.00	
	Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00
	TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.				N	87.00
				Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
				1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.				0	88.00
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
			1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.		0.00		0	89.00
				V	XIX	
				1.00	2.00	
	Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00

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		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	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	Y	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 8/31/2023 4:04 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	350,375	0	0	118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		Y	5.02	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	HB0778	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: DEACONESS HEALTH SYSTEM	Contractor's Name: NGS	Contractor's Number: 06101	141.00
142.00	Street: 600 MARY STREET	PO Box:		142.00
143.00	City: EVANSVILLE	State: IL	Zip Code: 47710	143.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 8/31/2023 4:04 pm

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

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

				1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act				
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)				168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			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: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 8/31/2023 4:04 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	08/14/2023	Y	08/14/2023	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 8/31/2023 4:04 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	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?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	09/30/2022	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.	BLUE AND CO	BLUE AND CO	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502-992-3500	CBRILL@BLUEANDCO.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.	BLUE AND CO		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: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 8/31/2023 4:04 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	39,216.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	39,216.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	39,216.00	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
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 8/31/2023 4:04 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,107	11	1,600			1.00
2.00	HMO and other (see instructions)	0	168				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	970	0	1,285			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	119			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,077	11	3,004			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)	2,077	11	3,004	0.00	233.85	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)	10,286	0	24,788	0.00	52.70	26.00
26.01	RURAL HEALTH CLINIC II	3,859	0	12,026	0.00	14.86	26.01
26.02	RURAL HEALTH CLINIC III	835	0	6,038	0.00	9.91	26.02
26.03	RURAL HEALTH CLINIC IV	1,305	0	4,792	0.00	8.95	26.03
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	320.27	27.00
28.00	Observation Bed Days		12	984			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 8/31/2023 4:04 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	310	3	519	1.00
2.00	HMO and other (see instructions)			0	53		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	310	3	519	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
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
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: 14-1324 | Component CCN: 14-8506 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-8 | Date/Time Prepared: 8/31/2023 4:04 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1201 PINE STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	EL DORADO		IL	62930	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC	13:00	17:00	07:00	19:00	07:00	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 2	13.00

		Provider name	CCN	
		1.00	2.00	
14.00	RHC/FQHC name, CCN	FERRELL HOSPITAL CLINIC	148506	14.00
14.01		ELDORADO FAMILY CLINIC	148507	14.01

		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		SALINE				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	19:00	07:00	19:00	07:00	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1324
Component CCN: 14-8506

Period:
From 04/01/2022
To 03/31/2023

Worksheet S-8
Date/Time Prepared:
8/31/2023 4:04 pm

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	19:00	09:00	17:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1324 | Component CCN: 14-8588 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-8 | Date/Time Prepared: 8/31/2023 4:04 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1340 HIGHWAY 1, SUITE A		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CARMI		IL	62821	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC	13:00	17:00	07:00	19:00	07:00	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.	N	0 13.00

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		WHITE				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	19:00	07:00	19:00	07:00	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1324 Component CCN: 14-8588	Period: From 04/01/2022 To 03/31/2023	Worksheet S-8 Date/Time Prepared: 8/31/2023 4:04 pm
		RHC II	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	19:00	09:00	17:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1324 | Component CCN: 14-8616 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-8 | Date/Time Prepared: 8/31/2023 4:04 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1340 IL-1		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CARMI		IL	62821	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC	13:00	17:00	08:00	18:00	07:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		WHITE				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	18:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1324
Component CCN: 14-8616

Period:
From 04/01/2022
To 03/31/2023

Worksheet S-8
Date/Time Prepared:
8/31/2023 4:04 pm

RHC III | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	17:00	09:00	17:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1324 | Component CCN: 14-8627 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-8 | Date/Time Prepared: 8/31/2023 4:04 pm

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			250 SMALL STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	HARRISBURG		IL	62946	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		SALINE				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: 14-1324 Component CCN: 14-8627	Period: From 04/01/2022 To 03/31/2023	Worksheet S-8 Date/Time Prepared: 8/31/2023 4:04 pm
		RHC IV	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	12:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-10 | Date/Time Prepared: 8/31/2023 4:04 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.533113	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,618,308	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	2,784,087	5.00
6.00	Medicaid charges	16,919,222	6.00
7.00	Medicaid cost (line 1 times line 6)	9,019,857	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)	3,617,462	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,617,462	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,366,069	0	1,366,069	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	728,269	0	728,269	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)	728,269	0	728,269	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,307,260	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	340,911	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	524,478	27.01
28.00	Non-Medicare bad debt expense (see instructions)	782,782	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	600,878	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,329,147	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,946,609	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A | Date/Time Prepared: 8/31/2023 4:04 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,480,434	2,480,434	-1,356,856	1,123,578	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD		0	0	82,130	82,130	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WIN		0	0	1,920,320	1,920,320	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	452,861	452,861	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	161,642	4,298,498	4,460,140	-4,454	4,455,686	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	521,171	920,376	1,441,547	27,312	1,468,859	5.01
5.02	00591	OTHER ADMIN AND GENERAL	660,198	4,250,004	4,910,202	-266,848	4,643,354	5.02
6.00	00600	MAINTENANCE & REPAIRS	319,198	904,845	1,224,043	-671,515	552,528	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	659,043	659,043	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	140	140	111,003	111,143	8.00
9.00	00900	HOUSEKEEPING	443,467	225,033	668,500	-122,156	546,344	9.00
10.00	01000	DIETARY	303,372	295,411	598,783	-295,314	303,469	10.00
11.00	01100	CAFETERIA	0	0	0	276,556	276,556	11.00
13.00	01300	NURSING ADMINISTRATION	361,676	61,529	423,205	-3,260	419,945	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	166,649	36,647	203,296	-40	203,256	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	548,849	548,849	-11,944	536,905	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,208,710	1,292,269	3,500,979	-13,663	3,487,316	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	655,788	991,822	1,647,610	-568,744	1,078,866	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	808,034	961,118	1,769,152	-47,963	1,721,189	54.00
60.00	06000	LABORATORY	1,059,875	1,894,059	2,953,934	-865,007	2,088,927	60.00
65.00	06500	RESPIRATORY THERAPY	478,796	105,733	584,529	-34,485	550,044	65.00
66.00	06600	PHYSICAL THERAPY	0	1,356,844	1,356,844	-2,873	1,353,971	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,792	4,792	1,803,472	1,808,264	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	155,569	155,569	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	220,891	4,085,515	4,306,406	-76,261	4,230,145	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,538,146	1,652,353	7,190,499	-117,169	7,073,330	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,430,959	142,396	1,573,355	-9,478	1,563,877	88.01
88.02	08802	RURAL HEALTH CLINIC III	724,593	107,836	832,429	166,070	998,499	88.02
88.03	08803	RURAL HEALTH CLINIC IV	498,449	101,803	600,252	0	600,252	88.03
90.00	09000	CLINIC	82,758	174,138	256,896	-686	256,210	90.00
90.01	09001	CLINIC - MCLEANSBORO	166,047	23	166,070	-166,070	0	90.01
90.02	09002	CLINIC - CHF	0	179	179	-179	0	90.02
90.03	09003	CLINIC - ORTHO	111,147	290,125	401,272	-2,286	398,986	90.03
91.00	09100	EMERGENCY	970,456	1,223,450	2,193,906	-166,802	2,027,104	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,505,413	1,505,413	-850,283	655,130	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,892,022	29,911,634	47,803,656	0	47,803,656	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		TOTAL (SUM OF LINES 118 through 199)	17,892,022	29,911,634	47,803,656	0	47,803,656	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A | Date/Time Prepared: 8/31/2023 4:04 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	1,123,578		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	82,130		1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WIN	0	1,920,320		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	452,861		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,273,959	5,729,645		4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	915	1,469,774		5.01
5.02	00591	OTHER ADMIN AND GENERAL	1,236,422	5,879,776		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	552,528		6.00
7.00	00700	OPERATION OF PLANT	412,482	1,071,525		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	111,143		8.00
9.00	00900	HOUSEKEEPING	180,403	726,747		9.00
10.00	01000	DIETARY	92,718	396,187		10.00
11.00	01100	CAFETERIA	-87,368	189,188		11.00
13.00	01300	NURSING ADMINISTRATION	48,968	468,913		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-13,944	189,312		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	536,905		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	228,275	3,715,591		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,078,866		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,791	1,719,398		54.00
60.00	06000	LABORATORY	0	2,088,927		60.00
65.00	06500	RESPIRATORY THERAPY	0	550,044		65.00
66.00	06600	PHYSICAL THERAPY	0	1,353,971		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,808,264		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	155,569		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,589	4,235,734		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	800,722	7,874,052		88.00
88.01	08801	RURAL HEALTH CLINIC II	173,283	1,737,160		88.01
88.02	08802	RURAL HEALTH CLINIC III	88,038	1,086,537		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	600,252		88.03
90.00	09000	CLINIC	0	256,210		90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0		90.01
90.02	09002	CLINIC - CHF	0	0		90.02
90.03	09003	CLINIC - ORTHO	0	398,986		90.03
91.00	09100	EMERGENCY	0	2,027,104		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-655,130	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,783,541	51,587,197		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	3,783,541	51,587,197		200.00

RECLASSIFICATIONS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-6 | Date/Time Prepared: 8/31/2023 4:04 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DEPRECIATION				
1.00	CAP REL COSTS-BLDG & FIXT - NEW WIN	1.02	0	1,920,320	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	357,798	2.00
	TOTALS		0	2,278,118	
	C - IMPLANT EXPENSE				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	155,569	1.00
	TOTALS		0	155,569	
	D - MEDICAL SUPPLY				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00		1,905,848	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
	TOTALS		0	1,905,848	
	E - OXYGEN EXPENSE				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	53,193	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
	TOTALS		0	53,193	
	F - PLANT OPERATIONS				
1.00	OPERATION OF PLANT	7.00	0	659,043	1.00
	TOTALS		0	659,043	
	G - PROPERTY TAXES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7,711	1.00
	TOTALS		0	7,711	
	H - CAFETERIA				
1.00	CAFETERIA	11.00	144,648	131,908	1.00
	TOTALS		144,648	131,908	
	I - HOSPITALIST				
1.00	ADULTS & PEDIATRICS	30.00	0	90,357	1.00
	TOTALS		0	90,357	
	J - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	57,226	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	95,063	2.00
	TOTALS		0	152,289	
	K - RHC BUSINESS OFFICE				
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.01	11,198	23,841	1.00
	TOTALS		11,198	23,841	
	L - EFM BUILDING RENT				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	13,753	1.00
2.00	CAP REL COSTS-BLDG & FIXT - EFM BLD	1.01	0	82,130	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	95,883	
	M - CLINIC - MCLEANSBORO				
1.00	RURAL HEALTH CLINIC III	88.02	166,047	23	1.00
	TOTALS		166,047	23	
	N - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	842,572	1.00
	TOTALS		0	842,572	

RECLASSIFICATIONS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-6 | Date/Time Prepared: 8/31/2023 4:04 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	O - CLINIC CHF					
1.00	OTHER ADMIN AND GENERAL	5.02	0	179		1.00
	TOTALS		0	179		
	P - HOUESEKEEPING					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	111,003		1.00
	TOTALS		0	111,003		
500.00	Grand Total: Increases		321,893	6,507,537		500.00

RECLASSIFICATIONS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-6 | Date/Time Prepared: 8/31/2023 4:04 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,278,118	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	2,278,118			
	C - IMPLANT EXPENSE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	155,569	0		1.00
	TOTALS		0	155,569			
	D - MEDICAL SUPPLY						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,454	0		1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.01	0	7,727	0		2.00
3.00	OTHER ADMIN AND GENERAL	5.02	0	110,463	0		3.00
4.00	MAINTENANCE & REPAIRS	6.00	0	12,472	0		4.00
5.00	HOUSEKEEPING	9.00	0	11,153	0		5.00
6.00	DIETARY	10.00	0	18,758	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	3,260	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	40	0		8.00
9.00	NONPHYSICIAN ANESTHETISTS	19.00	0	11,944	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	78,829	0		10.00
11.00	OPERATING ROOM	50.00	0	564,938	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	47,963	0		12.00
13.00	LABORATORY	60.00	0	863,785	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	11,511	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	2,873	0		15.00
16.00	DRUGS CHARGED TO PATIENTS	73.00	0	76,261	0		16.00
17.00	CLINIC	90.00	0	686	0		17.00
18.00	CLINIC - ORTHO	90.03	0	2,286	0		18.00
19.00	EMERGENCY	91.00	0	76,445	0		19.00
20.00	EMERGENCY				0		20.00
	TOTALS		0	1,905,848			
	E - OXYGEN EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	25,191	0		1.00
2.00	OPERATING ROOM	50.00	0	3,806	0		2.00
3.00	LABORATORY	60.00	0	1,222	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	22,974	0		4.00
	TOTALS		0	53,193			
	F - PLANT OPERATIONS						
1.00	MAINTENANCE & REPAIRS	6.00	0	659,043	0		1.00
	TOTALS		0	659,043			
	G - PROPERTY TAXES						
1.00	INTEREST EXPENSE	113.00	0	7,711	13		1.00
	TOTALS		0	7,711			
	H - CAFETERIA						
1.00	DIETARY	10.00	144,648	131,908	0		1.00
	TOTALS		144,648	131,908			
	I - HOSPITALIST						
1.00	EMERGENCY	91.00	0	90,357	0		1.00
	TOTALS		0	90,357			
	J - PROPERTY INSURANCE						
1.00	OTHER ADMIN AND GENERAL	5.02	0	152,289	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	152,289			
	K - RHC BUSINESS OFFICE						
1.00	RURAL HEALTH CLINIC	88.00	11,198	23,841	0		1.00
	TOTALS		11,198	23,841			
	L - EFM BUILDING RENT						
1.00	OTHER ADMIN AND GENERAL	5.02	0	4,275	10		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	82,130	10		2.00
3.00	RURAL HEALTH CLINIC II	88.01	0	9,478	0		3.00
	TOTALS		0	95,883			
	M - CLINIC - MCLEANSBORO						
1.00	CLINIC - MCLEANSBORO	90.01	166,047	23	0		1.00
	TOTALS		166,047	23			
	N - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	842,572	11		1.00
	TOTALS		0	842,572			
	O - CLINIC CHF						
1.00	CLINIC - CHF	90.02	0	179	0		1.00
	TOTALS		0	179			
	P - HOUESEKEEPING						
1.00	HOUSEKEEPING	9.00	0	111,003	0		1.00
	TOTALS		0	111,003			
500.00	Grand Total: Decreases		321,893	6,507,537			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 8/31/2023 4:04 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	188,327	10,000	0	10,000	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	16,588,695	1,923,882	0	1,923,882	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	28,979,662	521,086	0	521,086	0	6.00
7.00	HIT designated Assets	1,581,457	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	47,338,141	2,454,968	0	2,454,968	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	47,338,141	2,454,968	0	2,454,968	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	198,327	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	18,512,577	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	29,500,748	0	6.00
7.00	HIT designated Assets	1,581,457	0	7.00
8.00	Subtotal (sum of lines 1-7)	49,793,109	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	49,793,109	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 8/31/2023 4:04 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,480,434	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - NEW WIN	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,480,434	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2,480,434	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - NEW WIN	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	2,480,434	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 8/31/2023 4:04 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	18,710,904	0	18,710,904	0.375773	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0	0	0.000000	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - NEW WIN	31,082,205	0	31,082,205	0.624227	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	49,793,109	0	49,793,109	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	202,316	13,753	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0	0	0	82,130	1.01
1.02	CAP REL COSTS-BLDG & FIXT - NEW WIN	0	0	0	1,920,320	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	357,798	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,480,434	95,883	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	842,572	57,226	7,711	0	1,123,578	1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0	0	0	82,130	1.01
1.02	CAP REL COSTS-BLDG & FIXT - NEW WIN	0	0	0	0	1,920,320	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	95,063	0	0	452,861	2.00
3.00	Total (sum of lines 1-2)	842,572	152,289	7,711	0	3,578,889	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-8 | Date/Time Prepared: 8/31/2023 4:04 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - EFM BLD (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - EFM BLD	1.01	0	1.01
1.02	Investment income - CAP REL COSTS-BLDG & FIXT - NEW WIN (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - NEW WIN	1.02	0	1.02
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)	B	-92,905	INTEREST EXPENSE	113.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-84,835	DRUGS CHARGED TO PATIENTS	73.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,137	OTHER ADMIN AND GENERAL	5.02	0	7.00
8.00	Television and radio service (chapter 21)	A	-18,346	OTHER ADMIN AND GENERAL	5.02	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,791			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	4,853,153			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-87,368	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	39,020	RURAL HEALTH CLINIC	88.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-13,944	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - EFM BLD		0	CAP REL COSTS-BLDG & FIXT - EFM BLD	1.01	0	26.01
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT - NEW WIN		0	CAP REL COSTS-BLDG & FIXT - NEW WIN	1.02	0	26.02

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-8 | Date/Time Prepared: 8/31/2023 4:04 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
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	LOBBYING DUES	A	-12,082	OTHER ADMIN AND GENERAL	5.02	0	33.00
33.01	PROVIDER TAX OFFSET	A	-562,225	INTEREST EXPENSE	113.00	0	33.01
33.02	CARMI CLINIC MISC REVENUE	B	712	RURAL HEALTH CLINIC II	88.01	0	33.02
33.04	A & G PURCHASE DISCOUNTS	B	-1,767	OTHER ADMIN AND GENERAL	5.02	0	33.04
33.05	340B OFFSET	A	-181,092	DRUGS CHARGED TO PATIENTS	73.00	0	33.05
33.06	NON ALLOWABLE ADVERTISING - A&G	A	-44,639	OTHER ADMIN AND GENERAL	5.02	0	33.06
33.07	DONATIONS	B	915	CASHIERING/ACCOUNTS RECEIVABLE	5.01	0	33.07
33.08	A&G MISC INCOME	B	-8,128	OTHER ADMIN AND GENERAL	5.02	0	33.08
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		3,783,541				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: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 8/31/2023 4:04 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	DHS - HR/EMPLOYEE BENEFITS	1,273,959	0	1.00
2.00	5.02	OTHER ADMIN AND GENERAL	DHS - A&G	2,116,371	814,818	2.00
3.00	7.00	OPERATION OF PLANT	DHS - OPERATION PLANT	412,482	0	3.00
3.01	9.00	HOUSEKEEPING	DHS - HOUSEKEEPING	180,403	0	3.01
4.00	10.00	DIETARY	DHS - DIETARY	92,718	0	4.00
4.01	13.00	NURSING ADMINISTRATION	DHS - NURSING ADMIN	48,968	0	4.01
4.02	73.00	DRUGS CHARGED TO PATIENTS	DHS - PHARMACY	271,516	0	4.02
4.03	30.00	ADULTS & PEDIATRICS	DHS - CASE MANAGEMENT	228,275	0	4.03
4.04	88.00	RURAL HEALTH CLINIC	DHS - EL DORADO	46,512	0	4.04
4.05	88.01	RURAL HEALTH CLINIC II	DHS - CARMI	172,571	0	4.05
4.06	88.00	RURAL HEALTH CLINIC	DHS - FERRELL FAMILY	715,190	0	4.06
4.07	88.02	RURAL HEALTH CLINIC III	DHS - MCLEANSBORO	88,038	0	4.07
4.08	5.02	OTHER ADMIN AND GENERAL	DHS - RHC BUSINESS OFFICE	20,968	0	4.08
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,667,971	814,818	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	B		0.00	DEACONESS HLTH	0.00	6.00
7.00	B		0.00	DEACONESS HOSP	0.00	7.00
8.00	B		0.00	DRHS IL	0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(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: 14-1324	Period: From 04/01/2022 To 03/31/2023	Worksheet A-8-1 Date/Time Prepared: 8/31/2023 4:04 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,273,959	0		1.00
2.00	1,301,553	0		2.00
3.00	412,482	0		3.00
3.01	180,403	0		3.01
4.00	92,718	0		4.00
4.01	48,968	0		4.01
4.02	271,516	0		4.02
4.03	228,275	0		4.03
4.04	46,512	0		4.04
4.05	172,571	0		4.05
4.06	715,190	0		4.06
4.07	88,038	0		4.07
4.08	20,968	0		4.08
5.00	4,853,153			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: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 8/31/2023 4:04 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	70,861	0	70,861	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	1,791	1,791	0	0	0	2.00
3.00	91.00	EMERGENCY	1,072,386	0	1,072,386	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,145,038	1,791	1,143,247		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,791		2.00
3.00	91.00	EMERGENCY	0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,791		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/31/2023 4:04 pm

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	143.00	3,223.00	5,289.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	120.25	89.07	66.80	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	44.54	44.54	33.40			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					17,196	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					287,073	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					353,305	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					657,574	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					657,574	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					657,574	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/31/2023 4:04 pm

Physical Therapy | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	89.07	66.80	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	657,574		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	4,290		61.00
62.00	Supplies (see instructions)	8,700		62.00
63.00	Total allowance (sum of lines 57-62)	670,564		63.00
64.00	Total cost of outside supplier services (from your records)	562,536		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1324	Period: From 04/01/2022 To 03/31/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/31/2023 4:04 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.00	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	75.00	1,949.00	2,495.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	113.96	84.41	63.31	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	42.21	42.21	31.66			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	8,547	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	164,515	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	157,958	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	331,020	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	331,020	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	331,020	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/31/2023 4:04 pm

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	84.41	63.31	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		331,020	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		331,020	63.00
64.00	Total cost of outside supplier services (from your records)		293,692	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		0	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		0	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1324	Period: From 04/01/2022 To 03/31/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/31/2023 4:04 pm

		Speech Pathology	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.00	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	20.00	1,202.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	109.51	81.12	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.56	40.56	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		2,190	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		97,506	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		99,696	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		99,696	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0	22.00
23.00	Total salary equivalency (see instructions)		99,696	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		0	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		0	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/31/2023 4:04 pm

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	81.12	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	99,696		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	99,696		63.00
64.00	Total cost of outside supplier services (from your records)	79,437		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part I | Date/Time Prepared: 8/31/2023 4:04 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - EFM BLD	BLDG & FIXT - NEW WIN	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,123,578	1,123,578				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD	82,130	0	82,130			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WIN	1,920,320	0	0	1,920,320		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	452,861				452,861	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,729,645	6,375	0	0	3,015	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,469,774	571	0	5,891	270	5.01
5.02	00591	OTHER ADMIN AND GENERAL	5,879,776	151,257	0	379,011	71,528	5.02
6.00	00600	MAINTENANCE & REPAIRS	552,528	217,392	0	0	59,971	6.00
7.00	00700	OPERATION OF PLANT	1,071,525	0	911	0	1,070	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	111,143	20,877	0	0	5,760	8.00
9.00	00900	HOUSEKEEPING	726,747	6,985	206	0	2,168	9.00
10.00	01000	DIETARY	396,187	38,429	0	81,229	10,599	10.00
11.00	01100	CAFETERIA	189,188	0	0	54,832	0	11.00
13.00	01300	NURSING ADMINISTRATION	468,913	2,125	0	0	586	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	189,312	34,573	0	0	16,349	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	536,905	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,715,591	153,481	0	360,885	48,275	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,078,866	66,253	0	416,171	18,899	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,719,398	32,074	0	143,538	15,167	54.00
60.00	06000	LABORATORY	2,088,927	66,253	0	89,952	6,876	60.00
65.00	06500	RESPIRATORY THERAPY	550,044	26,190	0	20,166	7,221	65.00
66.00	06600	PHYSICAL THERAPY	1,353,971	24,124	0	35,233	6,653	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,808,264	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	155,569	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,235,734	13,518	0	68,427	3,731	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,874,052	147,578	81,013	22,488	139,094	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,737,160	96,417	0	0	26,594	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,086,537	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	600,252	0	0	0	0	88.03
90.00	09000	CLINIC	256,210	0	0	39,142	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0	90.02
90.03	09003	CLINIC - ORTHO	398,986	0	0	0	0	90.03
91.00	09100	EMERGENCY	2,027,104	19,106	0	188,174	9,035	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,587,197	1,123,578	82,130	1,905,139	452,861	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	15,181	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	201.00
202.00		TOTAL (sum lines 118 through 201)	51,587,197	1,123,578	82,130	1,920,320	452,861	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part I | Date/Time Prepared: 8/31/2023 4:04 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	MAINTENANCE & REPAIRS	
			4.00	5.01	5A.01	5.02	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WIN						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,739,035					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	336,050	1,812,556				5.01
5.02	00591	OTHER ADMIN AND GENERAL	257,500	0	6,739,072	6,739,072		5.02
6.00	00600	MAINTENANCE & REPAIRS	167,032	0	996,923	149,802	1,146,725	6.00
7.00	00700	OPERATION OF PLANT	0	0	1,073,506	161,309	1,858	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	137,780	20,703	17,141	8.00
9.00	00900	HOUSEKEEPING	361,511	0	1,097,617	164,932	6,155	9.00
10.00	01000	DIETARY	102,205	0	628,649	94,463	54,719	10.00
11.00	01100	CAFETERIA	93,177	0	337,197	50,669	15,639	11.00
13.00	01300	NURSING ADMINISTRATION	67,174	0	538,798	80,962	1,745	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	79,995	0	320,229	48,119	28,385	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	536,905	80,677	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	959,035	91,839	5,329,106	800,773	228,941	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	239,262	74,583	1,894,034	284,605	179,473	50.00
53.00	05300	ANESTHESIOLOGY	0	40,385	40,385	6,068	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	301,921	442,166	2,654,264	398,840	67,272	54.00
60.00	06000	LABORATORY	484,302	346,188	3,082,498	463,188	80,051	60.00
65.00	06500	RESPIRATORY THERAPY	172,630	46,783	823,034	123,672	27,255	65.00
66.00	06600	PHYSICAL THERAPY	0	102,791	1,522,772	228,818	29,856	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	54,093	1,862,357	279,845	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,477	163,046	24,500	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,699	240,260	4,605,369	692,021	30,615	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	951,630	157,663	9,373,518	1,408,518	292,770	88.00
88.01	08801	RURAL HEALTH CLINIC II	268,334	36,604	2,165,109	325,338	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	178,950	22,084	1,287,571	193,476	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	153,489	16,545	770,286	115,746	0	88.03
90.00	09000	CLINIC	33,406	12,477	341,235	51,275	11,164	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0	90.02
90.03	09003	CLINIC - ORTHO	52,367	14,404	465,757	69,987	0	90.03
91.00	09100	EMERGENCY	435,366	106,214	2,784,999	418,485	69,356	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,739,035	1,812,556	51,572,016	6,736,791	1,142,395	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	15,181	2,281	4,330	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	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)	5,739,035	1,812,556	51,587,197	6,739,072	1,146,725	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part I | Date/Time Prepared: 8/31/2023 4:04 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	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	CAP REL COSTS-BLDG & FIXT - EFM BLD						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WIN						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00591	OTHER ADMIN AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	1,236,673					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18,516	194,140				8.00
9.00	00900	HOUSEKEEPING	6,649	29,495	1,304,848			9.00
10.00	01000	DIETARY	59,107	538	63,661	901,137		10.00
11.00	01100	CAFETERIA	16,893	0	18,194	0	438,592	11.00
13.00	01300	NURSING ADMINISTRATION	1,885	0	2,030	0	7,702	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,662	0	33,024	0	9,181	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	247,300	116,960	266,353	901,137	110,097	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	193,864	21,224	208,800	0	27,473	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,666	13,577	78,265	0	34,649	54.00
60.00	06000	LABORATORY	86,470	119	93,132	0	55,588	60.00
65.00	06500	RESPIRATORY THERAPY	29,440	0	31,708	0	19,810	65.00
66.00	06600	PHYSICAL THERAPY	32,250	6,298	34,734	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,070	0	35,618	0	5,026	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	316,247	4,519	340,614	0	109,253	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
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	12,059	0	12,988	0	3,826	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0	90.02
90.03	09003	CLINIC - ORTHO	0	0	0	0	6,017	90.03
91.00	09100	EMERGENCY	74,918	1,410	80,690	0	49,970	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,231,996	194,140	1,299,811	901,137	438,592	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,677	0	5,037	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)	1,236,673	194,140	1,304,848	901,137	438,592	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part I | Date/Time Prepared: 8/31/2023 4:04 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	16.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WIN						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00591	OTHER ADMIN AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	633,122					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	469,600				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	617,582			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	336,168	224,879	0	8,561,714	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	83,886	0	0	2,893,359	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	617,582	664,035	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,614	0	3,326,147	0	54.00
60.00	06000	LABORATORY	0	6,614	0	3,867,660	0	60.00
65.00	06500	RESPIRATORY THERAPY	60,489	6,614	0	1,122,022	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,614	0	1,861,342	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,142,202	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	187,546	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,401,719	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	11,845,439	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,490,447	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,481,047	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	886,032	0	88.03
90.00	09000	CLINIC	0	99,211	0	531,758	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0	90.02
90.03	09003	CLINIC - ORTHO	0	0	0	541,761	0	90.03
91.00	09100	EMERGENCY	152,579	119,054	0	3,751,461	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	633,122	469,600	617,582	51,555,691	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	31,506	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	633,122	469,600	617,582	51,587,197	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part I | Date/Time Prepared: 8/31/2023 4:04 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WIN			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.01
5.02	00591	OTHER ADMIN AND GENERAL			5.02
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	8,561,714		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,893,359		50.00
53.00	05300	ANESTHESIOLOGY	664,035		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,326,147		54.00
60.00	06000	LABORATORY	3,867,660		60.00
65.00	06500	RESPIRATORY THERAPY	1,122,022		65.00
66.00	06600	PHYSICAL THERAPY	1,861,342		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,142,202		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	187,546		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,401,719		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	11,845,439		88.00
88.01	08801	RURAL HEALTH CLINIC II	2,490,447		88.01
88.02	08802	RURAL HEALTH CLINIC III	1,481,047		88.02
88.03	08803	RURAL HEALTH CLINIC IV	886,032		88.03
90.00	09000	CLINIC	531,758		90.00
90.01	09001	CLINIC - MCLEANSBORO	0		90.01
90.02	09002	CLINIC - CHF	0		90.02
90.03	09003	CLINIC - ORTHO	541,761		90.03
91.00	09100	EMERGENCY	3,751,461		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,555,691		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,506		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	51,587,197		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part II | Date/Time Prepared: 8/31/2023 4:04 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	BLDG & FIXT - EFM BLD	BLDG & FIXT - NEW WIN	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WIN						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,375	0	0	3,015	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	571	0	5,891	270	5.01
5.02	00591	OTHER ADMIN AND GENERAL	0	151,257	0	379,011	71,528	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	217,392	0	0	59,971	6.00
7.00	00700	OPERATION OF PLANT	0	0	911	0	1,070	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,877	0	0	5,760	8.00
9.00	00900	HOUSEKEEPING	0	6,985	206	0	2,168	9.00
10.00	01000	DIETARY	0	38,429	0	81,229	10,599	10.00
11.00	01100	CAFETERIA	0	0	0	54,832	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,125	0	0	586	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34,573	0	0	16,349	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	153,481	0	360,885	48,275	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	66,253	0	416,171	18,899	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,074	0	143,538	15,167	54.00
60.00	06000	LABORATORY	0	66,253	0	89,952	6,876	60.00
65.00	06500	RESPIRATORY THERAPY	0	26,190	0	20,166	7,221	65.00
66.00	06600	PHYSICAL THERAPY	0	24,124	0	35,233	6,653	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,518	0	68,427	3,731	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	147,578	81,013	22,488	139,094	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	96,417	0	0	26,594	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	39,142	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0	90.02
90.03	09003	CLINIC - ORTHO	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	19,106	0	188,174	9,035	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,123,578	82,130	1,905,139	452,861	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	15,181	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	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,123,578	82,130	1,920,320	452,861	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part II | Date/Time Prepared: 8/31/2023 4:04 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMIN AND GENERAL	MAINTENANCE & REPAIRS	
			2A	4.00	5.01	5.02	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WIN						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,390	9,390				4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	6,732	550	7,282			5.01
5.02	00591	OTHER ADMIN AND GENERAL	601,796	421	0	602,217		5.02
6.00	00600	MAINTENANCE & REPAIRS	277,363	273	0	13,387	291,023	6.00
7.00	00700	OPERATION OF PLANT	1,981	0	0	14,415	472	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,637	0	0	1,850	4,350	8.00
9.00	00900	HOUSEKEEPING	9,359	591	0	14,739	1,562	9.00
10.00	01000	DIETARY	130,257	167	0	8,441	13,887	10.00
11.00	01100	CAFETERIA	54,832	152	0	4,528	3,969	11.00
13.00	01300	NURSING ADMINISTRATION	2,711	110	0	7,235	443	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	50,922	131	0	4,300	7,204	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	7,210	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	562,641	1,572	367	71,559	58,102	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	501,323	391	298	25,433	45,548	50.00
53.00	05300	ANESTHESIOLOGY	0	0	162	542	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	190,779	494	1,801	35,641	17,073	54.00
60.00	06000	LABORATORY	163,081	792	1,385	41,392	20,316	60.00
65.00	06500	RESPIRATORY THERAPY	53,577	282	187	11,052	6,917	65.00
66.00	06600	PHYSICAL THERAPY	66,010	0	411	20,448	7,577	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	216	25,008	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	30	2,189	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85,676	71	961	61,841	7,770	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	390,173	1,557	631	125,864	74,299	88.00
88.01	08801	RURAL HEALTH CLINIC II	123,011	439	146	29,073	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	293	88	17,290	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	251	66	10,343	0	88.03
90.00	09000	CLINIC	39,142	55	50	4,582	2,833	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0	90.02
90.03	09003	CLINIC - ORTHO	0	86	58	6,254	0	90.03
91.00	09100	EMERGENCY	216,315	712	425	37,397	17,602	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,563,708	9,390	7,282	602,013	289,924	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,181	0	0	204	1,099	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	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)	3,578,889	9,390	7,282	602,217	291,023	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part II | Date/Time Prepared: 8/31/2023 4:04 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	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	CAP REL COSTS-BLDG & FIXT - EFM BLD						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WIN						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00591	OTHER ADMIN AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	16,868					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	253	33,090				8.00
9.00	00900	HOUSEKEEPING	91	5,027	31,369			9.00
10.00	01000	DIETARY	806	92	1,530	155,180		10.00
11.00	01100	CAFETERIA	230	0	437	0	64,148	11.00
13.00	01300	NURSING ADMINISTRATION	26	0	49	0	1,126	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	418	0	794	0	1,343	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,373	19,937	6,403	155,180	16,103	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,644	3,617	5,020	0	4,018	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	991	2,314	1,882	0	5,068	54.00
60.00	06000	LABORATORY	1,179	20	2,239	0	8,130	60.00
65.00	06500	RESPIRATORY THERAPY	402	0	762	0	2,897	65.00
66.00	06600	PHYSICAL THERAPY	440	1,073	835	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	451	0	856	0	735	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,314	770	8,189	0	15,979	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
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	164	0	312	0	560	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0	90.02
90.03	09003	CLINIC - ORTHO	0	0	0	0	880	90.03
91.00	09100	EMERGENCY	1,022	240	1,940	0	7,309	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,804	33,090	31,248	155,180	64,148	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	64	0	121	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)	16,868	33,090	31,369	155,180	64,148	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part II | Date/Time Prepared: 8/31/2023 4:04 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	16.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WIN						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00591	OTHER ADMIN AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	11,700					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	65,112				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	7,210			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,212	31,181		932,630	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,550	0		589,842	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0		704	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	917		256,960	0	54.00
60.00	06000	LABORATORY	0	917		239,451	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,118	917		78,111	0	65.00
66.00	06600	PHYSICAL THERAPY	0	917		97,711	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		25,224	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		2,219	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		158,361	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		621,776	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		152,669	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		17,671	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0		10,660	0	88.03
90.00	09000	CLINIC	0	13,756		61,454	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0		0	0	90.01
90.02	09002	CLINIC - CHF	0	0		0	0	90.02
90.03	09003	CLINIC - ORTHO	0	0		7,278	0	90.03
91.00	09100	EMERGENCY	2,820	16,507		302,289	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,700	65,112	0	3,555,010	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		16,669	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		0	0	192.00
200.00		Cross Foot Adjustments			7,210	7,210	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,700	65,112	7,210	3,578,889	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part II | Date/Time Prepared: 8/31/2023 4:04 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WIN			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.01
5.02	00591	OTHER ADMIN AND GENERAL			5.02
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	932,630		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	589,842		50.00
53.00	05300	ANESTHESIOLOGY	704		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	256,960		54.00
60.00	06000	LABORATORY	239,451		60.00
65.00	06500	RESPIRATORY THERAPY	78,111		65.00
66.00	06600	PHYSICAL THERAPY	97,711		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,224		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,219		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	158,361		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	621,776		88.00
88.01	08801	RURAL HEALTH CLINIC II	152,669		88.01
88.02	08802	RURAL HEALTH CLINIC III	17,671		88.02
88.03	08803	RURAL HEALTH CLINIC IV	10,660		88.03
90.00	09000	CLINIC	61,454		90.00
90.01	09001	CLINIC - MCLEANSBORO	0		90.01
90.02	09002	CLINIC - CHF	0		90.02
90.03	09003	CLINIC - ORTHO	7,278		90.03
91.00	09100	EMERGENCY	302,289		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,555,010		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,669		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
200.00		Cross Foot Adjustments	7,210		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,578,889		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B-1 | Date/Time Prepared: 8/31/2023 4:04 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - EFM BLD (SQUARE FEET)	BLDG & FIXT - NEW WIN (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (FTE'S)	
			1.00	1.01	1.02	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	57,101					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	10,366				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WIN	0	0	33,901			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				48,668		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	324	0	0	324	31,782	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	29	0	104	29	1,861	5.01
5.02	00591	OTHER ADMIN AND GENERAL	7,687	0	6,691	7,687	1,426	5.02
6.00	00600	MAINTENANCE & REPAIRS	11,048	0	0	6,445	925	6.00
7.00	00700	OPERATION OF PLANT	0	115	0	115	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,061	0	0	619	0	8.00
9.00	00900	HOUSEKEEPING	355	26	0	233	2,002	9.00
10.00	01000	DIETARY	1,953	0	1,434	1,139	566	10.00
11.00	01100	CAFETERIA	0	0	968	0	516	11.00
13.00	01300	NURSING ADMINISTRATION	108	0	0	63	372	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,757	0	0	1,757	443	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,800	0	6,371	5,188	5,311	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,367	0	7,347	2,031	1,325	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,630	0	2,534	1,630	1,672	54.00
60.00	06000	LABORATORY	3,367	0	1,588	739	2,682	60.00
65.00	06500	RESPIRATORY THERAPY	1,331	0	356	776	956	65.00
66.00	06600	PHYSICAL THERAPY	1,226	0	622	715	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	687	0	1,208	401	242	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,500	10,225	397	14,948	5,270	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,900	0	0	2,858	1,486	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	991	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	850	88.03
90.00	09000	CLINIC	0	0	691	0	185	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0	90.02
90.03	09003	CLINIC - ORTHO	0	0	0	0	290	90.03
91.00	09100	EMERGENCY	971	0	3,322	971	2,411	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	57,101	10,366	33,633	48,668	31,782	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	268	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						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,123,578	82,130	1,920,320	452,861	5,739,035	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.677028	7.923018	56.644937	9.305108	180.575011	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					9,390	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.295450	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: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B-1 | Date/Time Prepared: 8/31/2023 4:04 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
			5.01	5A.02	5.02	6.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WIN						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	96,706,834					5.01
5.02	00591	OTHER ADMIN AND GENERAL	0	-6,739,072	44,848,125			5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	996,923	70,980		6.00
7.00	00700	OPERATION OF PLANT	0	0	1,073,506	115	70,865	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	137,780	1,061	1,061	8.00
9.00	00900	HOUSEKEEPING	0	0	1,097,617	381	381	9.00
10.00	01000	DIETARY	0	0	628,649	3,387	3,387	10.00
11.00	01100	CAFETERIA	0	0	337,197	968	968	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	538,798	108	108	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	320,229	1,757	1,757	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	536,905	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,899,909	0	5,329,106	14,171	14,171	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,979,236	0	1,894,034	11,109	11,109	50.00
53.00	05300	ANESTHESIOLOGY	2,154,645	0	40,385	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,592,154	0	2,654,264	4,164	4,164	54.00
60.00	06000	LABORATORY	18,470,263	0	3,082,498	4,955	4,955	60.00
65.00	06500	RESPIRATORY THERAPY	2,496,040	0	823,034	1,687	1,687	65.00
66.00	06600	PHYSICAL THERAPY	5,484,221	0	1,522,772	1,848	1,848	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,886,058	0	1,862,357	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	398,920	0	163,046	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,818,652	0	4,605,369	1,895	1,895	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,411,815	0	9,373,518	18,122	18,122	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,952,917	0	2,165,109	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,178,260	0	1,287,571	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	882,732	0	770,286	0	0	88.03
90.00	09000	CLINIC	665,678	0	341,235	691	691	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0	90.02
90.03	09003	CLINIC - ORTHO	768,498	0	465,757	0	0	90.03
91.00	09100	EMERGENCY	5,666,836	0	2,784,999	4,293	4,293	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	96,706,834	-6,739,072	44,832,944	70,712	70,597	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	15,181	268	268	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						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,812,556		6,739,072	1,146,725	1,236,673	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.018743		0.150264	16.155607	17.451111	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,282		602,217	291,023	16,868	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000075		0.013428	4.100070	0.238030	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: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B-1 | Date/Time Prepared: 8/31/2023 4:04 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WIN						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00591	OTHER ADMIN AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	263,884					8.00
9.00	00900	HOUSEKEEPING	40,091	69,423				9.00
10.00	01000	DIETARY	731	3,387	1,600			10.00
11.00	01100	CAFETERIA	0	968	0	440,090		11.00
13.00	01300	NURSING ADMINISTRATION	0	108	0	7,728	208,059	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,757	0	9,212	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	158,978	14,171	1,600	110,473	110,473	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,848	11,109	0	27,567	27,567	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,455	4,164	0	34,767	0	54.00
60.00	06000	LABORATORY	162	4,955	0	55,778	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,687	0	19,878	19,878	65.00
66.00	06600	PHYSICAL THERAPY	8,560	1,848	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,895	0	5,043	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,142	18,122	0	109,626	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
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	691	0	3,839	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0	90.02
90.03	09003	CLINIC - ORTHO	0	0	0	6,038	0	90.03
91.00	09100	EMERGENCY	1,917	4,293	0	50,141	50,141	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	263,884	69,155	1,600	440,090	208,059	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	268	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						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	194,140	1,304,848	901,137	438,592	633,122	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.735702	18.795615	563.210625	0.996596	3.042993	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	33,090	31,369	155,180	64,148	11,700	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.125396	0.451853	96.987500	0.145761	0.056234	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: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B-1 | Date/Time Prepared: 8/31/2023 4:04 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	19.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - EFM BLD				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - NEW WIN				1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.01
5.02	00591	OTHER ADMIN AND GENERAL				5.02
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,260			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	2,040	0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	60	0		54.00
60.00	06000	LABORATORY	60	0		60.00
65.00	06500	RESPIRATORY THERAPY	60	0		65.00
66.00	06600	PHYSICAL THERAPY	60	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0		88.03
90.00	09000	CLINIC	900	0		90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0		90.01
90.02	09002	CLINIC - CHF	0	0		90.02
90.03	09003	CLINIC - ORTHO	0	0		90.03
91.00	09100	EMERGENCY	1,080	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,260	100		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
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)	469,600	617,582		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	110.234742	6,175.820000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	65,112	7,210		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	15.284507	72.100000		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: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet C Part I Date/Time Prepared: 8/31/2023 4:04 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,561,714		8,561,714	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,893,359		2,893,359	0	0	50.00
53.00	05300	ANESTHESIOLOGY	664,035		664,035	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,326,147		3,326,147	0	0	54.00
60.00	06000	LABORATORY	3,867,660		3,867,660	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,122,022	0	1,122,022	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,861,342	0	1,861,342	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,142,202		2,142,202	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	187,546		187,546	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,401,719		5,401,719	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	11,845,439		11,845,439	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,490,447		2,490,447	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,481,047		1,481,047	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	886,032		886,032	0	0	88.03
90.00	09000	CLINIC	531,758		531,758	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0		0	0	0	90.01
90.02	09002	CLINIC - CHF	0		0	0	0	90.02
90.03	09003	CLINIC - ORTHO	541,761		541,761	0	0	90.03
91.00	09100	EMERGENCY	3,751,461		3,751,461	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,172,652		2,172,652		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	53,728,343	0	53,728,343	0	0	200.00
201.00		Less Observation Beds	2,172,652		2,172,652		0	201.00
202.00		Total (see instructions)	51,555,691	0	51,555,691	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet C Part I | Date/Time Prepared: 8/31/2023 4:04 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,504,320		3,504,320			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	186,339	3,792,897	3,979,236	0.727114	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	86,919	2,067,726	2,154,645	0.308188	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,273,574	22,318,580	23,592,154	0.140985	0.000000	54.00
60.00	06000	LABORATORY	1,338,116	17,132,147	18,470,263	0.209399	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	731,034	1,765,006	2,496,040	0.449521	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,647,672	2,836,549	5,484,221	0.339400	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	880,204	2,005,854	2,886,058	0.742259	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	102,472	296,448	398,920	0.470134	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,249,117	10,569,535	12,818,652	0.421395	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	8,411,815	8,411,815			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,952,917	1,952,917			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,178,260	1,178,260			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	882,732	882,732			88.03
90.00	09000	CLINIC	0	665,678	665,678	0.798822	0.000000	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC - CHF	0	0	0	0.000000	0.000000	90.02
90.03	09003	CLINIC - ORTHO	0	768,498	768,498	0.704961	0.000000	90.03
91.00	09100	EMERGENCY	389,752	5,277,084	5,666,836	0.662003	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	202,836	1,192,753	1,395,589	1.556799	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	13,592,355	83,114,479	96,706,834			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,592,355	83,114,479	96,706,834			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet C Part I Date/Time Prepared: 8/31/2023 4:04 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		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
88.03	08803	RURAL HEALTH CLINIC IV			88.03
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC - MCLEANSBORO	0.000000		90.01
90.02	09002	CLINIC - CHF	0.000000		90.02
90.03	09003	CLINIC - ORTHO	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet C Part I Date/Time Prepared: 8/31/2023 4:04 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,561,714		8,561,714	0	8,561,714	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,893,359		2,893,359	0	2,893,359	50.00
53.00	05300	ANESTHESIOLOGY	664,035		664,035	0	664,035	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,326,147		3,326,147	0	3,326,147	54.00
60.00	06000	LABORATORY	3,867,660		3,867,660	0	3,867,660	60.00
65.00	06500	RESPIRATORY THERAPY	1,122,022	0	1,122,022	0	1,122,022	65.00
66.00	06600	PHYSICAL THERAPY	1,861,342	0	1,861,342	0	1,861,342	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,142,202		2,142,202	0	2,142,202	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	187,546		187,546	0	187,546	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,401,719		5,401,719	0	5,401,719	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	11,845,439		11,845,439	0	11,845,439	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,490,447		2,490,447	0	2,490,447	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,481,047		1,481,047	0	1,481,047	88.02
88.03	08803	RURAL HEALTH CLINIC IV	886,032		886,032	0	886,032	88.03
90.00	09000	CLINIC	531,758		531,758	0	531,758	90.00
90.01	09001	CLINIC - MCLEANSBORO	0		0	0	0	90.01
90.02	09002	CLINIC - CHF	0		0	0	0	90.02
90.03	09003	CLINIC - ORTHO	541,761		541,761	0	541,761	90.03
91.00	09100	EMERGENCY	3,751,461		3,751,461	0	3,751,461	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,172,652		2,172,652		2,172,652	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	53,728,343	0	53,728,343	0	53,728,343	200.00
201.00		Less Observation Beds	2,172,652		2,172,652		2,172,652	201.00
202.00		Total (see instructions)	51,555,691	0	51,555,691	0	51,555,691	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet C Part I Date/Time Prepared: 8/31/2023 4:04 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,504,320		3,504,320			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	186,339	3,792,897	3,979,236	0.727114	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	86,919	2,067,726	2,154,645	0.308188	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,273,574	22,318,580	23,592,154	0.140985	0.000000	54.00
60.00	06000	LABORATORY	1,338,116	17,132,147	18,470,263	0.209399	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	731,034	1,765,006	2,496,040	0.449521	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,647,672	2,836,549	5,484,221	0.339400	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	880,204	2,005,854	2,886,058	0.742259	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	102,472	296,448	398,920	0.470134	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,249,117	10,569,535	12,818,652	0.421395	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	8,411,815	8,411,815	1.408191	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,952,917	1,952,917	1.275245	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,178,260	1,178,260	1.256978	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	882,732	882,732	1.003738	0.000000	88.03
90.00	09000	CLINIC	0	665,678	665,678	0.798822	0.000000	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC - CHF	0	0	0	0.000000	0.000000	90.02
90.03	09003	CLINIC - ORTHO	0	768,498	768,498	0.704961	0.000000	90.03
91.00	09100	EMERGENCY	389,752	5,277,084	5,666,836	0.662003	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	202,836	1,192,753	1,395,589	1.556799	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	13,592,355	83,114,479	96,706,834			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,592,355	83,114,479	96,706,834			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet C Part I Date/Time Prepared: 8/31/2023 4:04 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		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
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		88.03
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC - MCLEANSBORO	0.000000		90.01
90.02	09002	CLINIC - CHF	0.000000		90.02
90.03	09003	CLINIC - ORTHO	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part II Date/Time Prepared: 8/31/2023 4:04 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	589,842	3,979,236	0.148230	51,884	7,691	50.00
53.00	05300	ANESTHESIOLOGY	704	2,154,645	0.000327	26,320	9	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	256,960	23,592,154	0.010892	380,801	4,148	54.00
60.00	06000	LABORATORY	239,451	18,470,263	0.012964	524,906	6,805	60.00
65.00	06500	RESPIRATORY THERAPY	78,111	2,496,040	0.031294	279,620	8,750	65.00
66.00	06600	PHYSICAL THERAPY	97,711	5,484,221	0.017817	371,957	6,627	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,224	2,886,058	0.008740	376,118	3,287	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,219	398,920	0.005563	48,360	269	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	158,361	12,818,652	0.012354	913,934	11,291	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	621,776	8,411,815	0.073917	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	152,669	1,952,917	0.078175	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	17,671	1,178,260	0.014998	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	10,660	882,732	0.012076	0	0	88.03
90.00	09000	CLINIC	61,454	665,678	0.092318	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0.000000	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	0.000000	0	0	90.02
90.03	09003	CLINIC - ORTHO	7,278	768,498	0.009470	0	0	90.03
91.00	09100	EMERGENCY	302,289	5,666,836	0.053344	84,945	4,531	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	236,667	1,395,589	0.169582	15,515	2,631	92.00
200.00		Total (lines 50 through 199)	2,859,047	93,202,514		3,074,360	56,039	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part IV | Date/Time Prepared: 8/31/2023 4:04 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	617,582	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		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
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0	90.02
90.03	09003	CLINIC - ORTHO	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	617,582	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part IV | Date/Time Prepared: 8/31/2023 4:04 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	3,979,236	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	617,582	0	2,154,645	0.286628	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,592,154	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	18,470,263	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,496,040	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,484,221	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,886,058	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	398,920	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,818,652	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	8,411,815	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,952,917	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,178,260	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	882,732	0.000000	88.03
90.00	09000	CLINIC	0	0	0	665,678	0.000000	90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0	0	0	0.000000	90.01
90.02	09002	CLINIC - CHF	0	0	0	0	0.000000	90.02
90.03	09003	CLINIC - ORTHO	0	0	0	768,498	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	5,666,836	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,395,589	0.000000	92.00
200.00		Total (lines 50 through 199)	0	617,582	0	93,202,514		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part IV | Date/Time Prepared: 8/31/2023 4:04 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	51,884	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	26,320	7,544	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	380,801	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	524,906	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	279,620	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	371,957	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	376,118	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	48,360	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	913,934	0	0	0	73.00
		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
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0.000000	0	0	0	0	90.02
90.03	09003	CLINIC - ORTHO	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	84,945	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	15,515	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,074,360	7,544	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part V Date/Time Prepared: 8/31/2023 4:04 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.727114	0	1,006,086	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.308188	0	424,108	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140985	0	8,047,185	0	0	54.00
60.00	06000	LABORATORY	0.209399	0	6,672,856	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.449521	0	837,118	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.339400	0	1,005,698	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.742259	0	554,552	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.470134	0	99,987	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.421395	0	4,710,235	0	0	73.00
		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
88.03	08803	RURAL HEALTH CLINIC IV						88.03
90.00	09000	CLINIC	0.798822	0	663,674	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0.000000	0	0	0	0	90.02
90.03	09003	CLINIC - ORTHO	0.704961	0	35,619	0	0	90.03
91.00	09100	EMERGENCY	0.662003	0	1,841,076	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.556799	0	539,184	0	0	92.00
200.00		Subtotal (see instructions)		0	26,437,378	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	26,437,378	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part V Date/Time Prepared: 8/31/2023 4:04 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	731,539	0		50.00
53.00	05300	ANESTHESIOLOGY	130,705	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,134,532	0		54.00
60.00	06000	LABORATORY	1,397,289	0		60.00
65.00	06500	RESPIRATORY THERAPY	376,302	0		65.00
66.00	06600	PHYSICAL THERAPY	341,334	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	411,621	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,007	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,984,869	0		73.00
		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
88.03	08803	RURAL HEALTH CLINIC IV				88.03
90.00	09000	CLINIC	530,157	0		90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0		90.01
90.02	09002	CLINIC - CHF	0	0		90.02
90.03	09003	CLINIC - ORTHO	25,110	0		90.03
91.00	09100	EMERGENCY	1,218,798	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	839,401	0		92.00
200.00		Subtotal (see instructions)	9,168,664	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	9,168,664	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part V Date/Time Prepared: 8/31/2023 4:04 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.727114	0	84,868	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.308188	0	14,382	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140985	0	653,625	0	0	54.00
60.00	06000	LABORATORY	0.209399	0	344,114	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.449521	0	51,736	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.339400	0	30,558	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.742259	0	45,683	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.470134	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.421395	0	174,402	0	0	73.00
		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
88.03	08803	RURAL HEALTH CLINIC IV						88.03
90.00	09000	CLINIC	0.798822	0	1,739	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC - CHF	0.000000	0	0	0	0	90.02
90.03	09003	CLINIC - ORTHO	0.704961	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.662003	0	170,836	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.556799	0	17,416	0	0	92.00
200.00		Subtotal (see instructions)		0	1,589,359	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	1,589,359	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part V Date/Time Prepared: 8/31/2023 4:04 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	61,709	0		50.00
53.00	05300	ANESTHESIOLOGY	4,432	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	92,151	0		54.00
60.00	06000	LABORATORY	72,057	0		60.00
65.00	06500	RESPIRATORY THERAPY	23,256	0		65.00
66.00	06600	PHYSICAL THERAPY	10,371	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	33,909	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73,492	0		73.00
		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
88.03	08803	RURAL HEALTH CLINIC IV				88.03
90.00	09000	CLINIC	1,389	0		90.00
90.01	09001	CLINIC - MCLEANSBORO	0	0		90.01
90.02	09002	CLINIC - CHF	0	0		90.02
90.03	09003	CLINIC - ORTHO	0	0		90.03
91.00	09100	EMERGENCY	113,094	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	27,113	0		92.00
200.00		Subtotal (see instructions)	512,973	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	512,973	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-1 | Date/Time Prepared: 8/31/2023 4:04 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,988	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,584	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)	1,600	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	964	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)	321	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	89	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)	30	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,107	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)	728	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)	242	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	159.97	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	159.97	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,561,714	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)	14,237	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)	4,799	25.00
26.00	Total swing-bed cost (see instructions)	2,856,290	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,705,424	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)	5,705,424	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)	2,207.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,444,234	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,444,234	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-1 | Date/Time Prepared: 8/31/2023 4:04 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,228,805	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	3,673,039	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)	1,607,409	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	534,331	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	2,141,740	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)	984	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,207.98	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1324	Period: From 04/01/2022 To 03/31/2023	Worksheet D-1 Date/Time Prepared: 8/31/2023 4:04 pm
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,172,652	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	932,630	8,561,714	0.108930	2,172,652	236,667	90.00
91.00	Nursing Program cost	0	8,561,714	0.000000	2,172,652	0	91.00
92.00	Allied health cost	0	8,561,714	0.000000	2,172,652	0	92.00
93.00	All other Medical Education	0	8,561,714	0.000000	2,172,652	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-1 | Date/Time Prepared: 8/31/2023 4:04 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,988	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,584	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)	1,600	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	964	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)	321	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	89	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)	30	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	159.97	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	159.97	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,561,714	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)	14,237	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)	4,799	25.00
26.00	Total swing-bed cost (see instructions)	2,856,290	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,705,424	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)	5,705,424	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)	2,207.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	24,288	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)	24,288	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-1 | Date/Time Prepared: 8/31/2023 4:04 pm

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	28,709	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)	52,997	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)	984	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,207.98	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1324	Period: From 04/01/2022 To 03/31/2023	Worksheet D-1 Date/Time Prepared: 8/31/2023 4:04 pm
	Title XIX	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,172,652	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	932,630	8,561,714	0.108930	2,172,652	236,667	90.00
91.00	Nursing Program cost	0	8,561,714	0.000000	2,172,652	0	91.00
92.00	Allied health cost	0	8,561,714	0.000000	2,172,652	0	92.00
93.00	All other Medical Education	0	8,561,714	0.000000	2,172,652	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-3 | Date/Time Prepared: 8/31/2023 4:04 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,682,577		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.727114	51,884	37,726	50.00
53.00	05300	ANESTHESIOLOGY	0.308188	26,320	8,112	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140985	380,801	53,687	54.00
60.00	06000	LABORATORY	0.209399	524,906	109,915	60.00
65.00	06500	RESPIRATORY THERAPY	0.449521	279,620	125,695	65.00
66.00	06600	PHYSICAL THERAPY	0.339400	371,957	126,242	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.742259	376,118	279,177	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.470134	48,360	22,736	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.421395	913,934	385,127	73.00
		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
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	0.798822	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0.000000	0	0	90.01
90.02	09002	CLINIC - CHF	0.000000	0	0	90.02
90.03	09003	CLINIC - ORTHO	0.704961	0	0	90.03
91.00	09100	EMERGENCY	0.662003	84,945	56,234	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.556799	15,515	24,154	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,074,360	1,228,805	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)		3,074,360		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1324 | Component CCN: 14-Z324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-3 | Date/Time Prepared: 8/31/2023 4:04 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.727114	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.308188	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140985	70,922	9,999	54.00
60.00	06000	LABORATORY	0.209399	136,142	28,508	60.00
65.00	06500	RESPIRATORY THERAPY	0.449521	164,903	74,127	65.00
66.00	06600	PHYSICAL THERAPY	0.339400	1,501,478	509,602	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.742259	161,710	120,031	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.470134	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.421395	316,714	133,462	73.00
		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
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	0.798822	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0.000000	0	0	90.01
90.02	09002	CLINIC - CHF	0.000000	0	0	90.02
90.03	09003	CLINIC - ORTHO	0.704961	0	0	90.03
91.00	09100	EMERGENCY	0.662003	165	109	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.556799	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,352,034	875,838	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,352,034		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-3 | Date/Time Prepared: 8/31/2023 4:04 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		16,536		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.727114	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.308188	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140985	18,140	2,557	54.00
60.00	06000	LABORATORY	0.209399	11,078	2,320	60.00
65.00	06500	RESPIRATORY THERAPY	0.449521	2,362	1,062	65.00
66.00	06600	PHYSICAL THERAPY	0.339400	3,589	1,218	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.742259	4,791	3,556	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.470134	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.421395	13,219	5,570	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.408191	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.275245	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.256978	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1.003738	0	0	88.03
90.00	09000	CLINIC	0.798822	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0.000000	0	0	90.01
90.02	09002	CLINIC - CHF	0.000000	0	0	90.02
90.03	09003	CLINIC - ORTHO	0.704961	0	0	90.03
91.00	09100	EMERGENCY	0.662003	3,177	2,103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.556799	6,631	10,323	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		62,987	28,709	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)		62,987		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1324 | Component CCN: 14-Z324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-3 | Date/Time Prepared: 8/31/2023 4:04 pm

Title XIX | 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	0.727114	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.308188	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140985	0	0	54.00
60.00	06000	LABORATORY	0.209399	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.449521	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.339400	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.742259	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.470134	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.421395	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.408191	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.275245	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.256978	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1.003738	0	0	88.03
90.00	09000	CLINIC	0.798822	0	0	90.00
90.01	09001	CLINIC - MCLEANSBORO	0.000000	0	0	90.01
90.02	09002	CLINIC - CHF	0.000000	0	0	90.02
90.03	09003	CLINIC - ORTHO	0.704961	0	0	90.03
91.00	09100	EMERGENCY	0.662003	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.556799	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1324	Period: From 04/01/2022 To 03/31/2023	Worksheet E Part B Date/Time Prepared: 8/31/2023 4:04 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,168,664	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)	9,168,664	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)	9,260,351	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)	81,873	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,002,409	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)	5,176,069	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)	5,176,069	30.00
31.00	Primary payer payments	1,673	31.00
32.00	Subtotal (line 30 minus line 31)	5,174,396	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)	483,215	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	314,090	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	483,215	36.00
37.00	Subtotal (see instructions)	5,488,486	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	5,488,486	40.00
40.01	Sequestration adjustment (see instructions)	96,048	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	6,279,975	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-887,537	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: 14-1324	Period: From 04/01/2022 To 03/31/2023	Worksheet E Part B Date/Time Prepared: 8/31/2023 4:04 pm
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 8/31/2023 4:04 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,097,363		6,994,763	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	10/19/2022	44,624		0	3.01
3.02		12/14/2022	18,113		0	3.02
3.03		03/29/2023	264,171		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	10/19/2022	457,894	3.50
3.51			0	12/14/2022	224,036	3.51
3.52			0	03/29/2023	32,858	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)		326,908		-714,788	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,424,271		6,279,975	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		74,568		887,537	6.02
7.00	Total Medicare program liability (see instructions)		3,349,703		5,392,438	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: 14-1324 | Component CCN: 14-Z324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 8/31/2023 4:04 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,295,173		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	10/19/2022	42,573		0	3.01
3.02		12/14/2022	9,735		0	3.02
3.03		03/29/2023	1,078		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)		53,386		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,348,559		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		635,240		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,983,799		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: 14-1324	Period: From 04/01/2022 To 03/31/2023	Worksheet E-1 Part II Date/Time Prepared: 8/31/2023 4:04 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1324 | Component CCN: 14-Z324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet E-2 | Date/Time Prepared: 8/31/2023 4:04 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	2,163,157	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)	884,596	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	970	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)	3,047,753	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	3,047,753	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)	3,047,753	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	10,808	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	3,036,945	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)	3,036,945	0	19.00
19.01	Sequestration adjustment (see instructions)	53,146	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	2,348,559	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	635,240	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-1324 | Component CCN: 14-Z324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet E-2 | Date/Time Prepared: 8/31/2023 4:04 pm

Title XIX | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0		3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	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)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0		19.25
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0		21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	0		22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		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: 14-1324	Period: From 04/01/2022 To 03/31/2023	Worksheet E-3 Part V Date/Time Prepared: 8/31/2023 4:04 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,673,039	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	3,673,039	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,709,769	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,709,769	19.00
20.00	Deductibles (exclude professional component)	326,024	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,383,745	22.00
23.00	Coinsurance	1,200	23.00
24.00	Subtotal (line 22 minus line 23)	3,382,545	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	41,263	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	26,821	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	41,263	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,409,366	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	3,409,366	30.00
30.01	Sequestration adjustment (see instructions)	59,663	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	3,424,271	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-74,568	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1324	Period: From 04/01/2022 To 03/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 8/31/2023 4:04 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	52,997		1.00
2.00	Medical and other services		512,973	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	53,527	518,103	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)	53,527	518,103	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	62,987	1,589,359	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)	62,987	1,589,359	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)	62,987	1,589,359	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	9,460	1,071,256	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)	53,527	518,103	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)	53,527	518,103	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)	53,527	518,103	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)	53,527	518,103	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	53,527	518,103	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)	53,527	518,103	40.00
41.00	Interim payments	53,527	518,103	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet G | Date/Time Prepared: 8/31/2023 4:04 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3,634,499	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,601,921	0	0	0	4.00
5.00	Other receivable	598,815	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,006,528	0	0	0	7.00
8.00	Prepaid expenses	407,115	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)	8,248,878	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	198,327	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	-43,063	0	0	0	14.00
15.00	Buildings	18,512,577	0	0	0	15.00
16.00	Accumulated depreciation	-3,000,261	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	31,082,205	0	0	0	23.00
24.00	Accumulated depreciation	-9,579,331	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	37,170,454	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	5,894,442	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,894,442	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	51,313,774	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,134,410	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,677,640	0	0	0	38.00
39.00	Payroll taxes payable	105,610	0	0	0	39.00
40.00	Notes and loans payable (short term)	888,112	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,805,772	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	36,424,362	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	36,424,362	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	44,230,134	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	7,083,640				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)	7,083,640	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	51,313,774	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet G-1 | Date/Time Prepared: 8/31/2023 4:04 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		8,235,112		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,151,472				2.00
3.00	Total (sum of line 1 and line 2)		7,083,640		0		3.00
4.00	Additions (credit adjustments) (specify)	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)		7,083,640		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		7,083,640		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	Additions (credit adjustments) (specify)		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	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/31/2023 4:04 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,781,777		3,781,777	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,781,777		3,781,777	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)	3,781,777		3,781,777	17.00
18.00	Ancillary services	9,810,215	69,255,473	79,065,688	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	8,411,815	8,411,815	20.00
20.01	RURAL HEALTH CLINIC II	0	1,952,917	1,952,917	20.01
20.02	RURAL HEALTH CLINIC III	0	681,861	681,861	20.02
20.03	RURAL HEALTH CLINIC IV	0	882,732	882,732	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	SENIOR CARE CLINIC	0	1,974,764	1,974,764	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	13,591,992	83,159,562	96,751,554	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		47,803,656		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)		47,803,656		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1324 | Period: From 04/01/2022 To 03/31/2023 | Worksheet G-3 | Date/Time Prepared: 8/31/2023 4:04 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	96,751,554	1.00
2.00	Less contractual allowances and discounts on patients' accounts	52,907,069	2.00
3.00	Net patient revenues (line 1 minus line 2)	43,844,485	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	47,803,656	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,959,171	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	2,005,816	6.00
7.00	Income from investments	92,905	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	1,767	10.00
11.00	Rebates and refunds of expenses	84,835	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	87,368	14.00
15.00	Revenue from rental of living quarters	-39,020	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	13,944	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	560,084	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	2,807,699	25.00
26.00	Total (line 5 plus line 25)	-1,151,472	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,151,472	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1324 | Component CCN: 14-8506 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-1 | Date/Time Prepared: 8/31/2023 4:04 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,881,571	0	1,881,571	-27,072	1,854,499	1.00
2.00	Physician Assistant	540,334	0	540,334	0	540,334	2.00
3.00	Nurse Practitioner	122,463	0	122,463	0	122,463	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	26,537	0	26,537	0	26,537	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	124,730	0	124,730	0	124,730	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,695,635	0	2,695,635	-27,072	2,668,563	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	278,295	278,295	21	278,316	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	278,295	278,295	21	278,316	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,695,635	278,295	2,973,930	-27,051	2,946,879	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	74,159	74,159	-55,613	18,546	29.00
30.00	Administrative Costs	2,842,511	1,299,899	4,142,410	-34,505	4,107,905	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	2,842,511	1,374,058	4,216,569	-90,118	4,126,451	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	5,538,146	1,652,353	7,190,499	-117,169	7,073,330	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1324 | Component CCN: 14-8506 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-1 | Date/Time Prepared: 8/31/2023 4:04 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,854,499		1.00
2.00	Physician Assistant	0	540,334		2.00
3.00	Nurse Practitioner	0	122,463		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	26,537		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	124,730		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,668,563		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	278,316		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	278,316		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,946,879		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	39,020	57,566		29.00
30.00	Administrative Costs	761,702	4,869,607		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	800,722	4,927,173		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	800,722	7,874,052		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1324 | Component CCN: 14-8588 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-1 | Date/Time Prepared: 8/31/2023 4:04 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	161,712	0	161,712	0	161,712	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	214,250	0	214,250	0	214,250	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	411	0	411	0	411	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	376,373	0	376,373	0	376,373	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	31,013	31,013	0	31,013	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	31,013	31,013	0	31,013	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	376,373	31,013	407,386	0	407,386	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	42,884	42,884	-9,478	33,406	29.00
30.00	Administrative Costs	1,054,586	68,499	1,123,085	0	1,123,085	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,054,586	111,383	1,165,969	-9,478	1,156,491	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,430,959	142,396	1,573,355	-9,478	1,563,877	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1324 | Component CCN: 14-8588 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-1 | Date/Time Prepared: 8/31/2023 4:04 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	161,712		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	214,250		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	411		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	376,373		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	31,013		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	31,013		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	407,386		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	712	34,118		29.00
30.00	Administrative Costs	172,571	1,295,656		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	173,283	1,329,774		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	173,283	1,737,160		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1324 | Component CCN: 14-8616 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-1 | Date/Time Prepared: 8/31/2023 4:04 pm

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	-1,473	0	-1,473	120,992	119,519	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	29,837	0	29,837	173,752	203,589	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	28,364	0	28,364	294,744	323,108	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	52,844	52,844	0	52,844	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	52,844	52,844	0	52,844	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	28,364	52,844	81,208	294,744	375,952	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	47,241	47,241	0	47,241	29.00
30.00	Administrative Costs	696,229	7,751	703,980	-294,744	409,236	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	696,229	54,992	751,221	-294,744	456,477	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	724,593	107,836	832,429	0	832,429	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1324 | Component CCN: 14-8616 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-1 | Date/Time Prepared: 8/31/2023 4:04 pm

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	119,519		1.00
2.00	Physician Assistant	3,061	3,061		2.00
3.00	Nurse Practitioner	157,269	360,858		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	160,330	483,438		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	52,844		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	52,844		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	160,330	536,282		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	47,241		29.00
30.00	Administrative Costs	93,778	503,014		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	93,778	550,255		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	254,108	1,086,537		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1324 | Component CCN: 14-8627 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-1 | Date/Time Prepared: 8/31/2023 4:04 pm

RHC IV | 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	14,105	0	14,105	136,839	150,944	1.00
2.00	Physician Assistant	4,821	0	4,821	0	4,821	2.00
3.00	Nurse Practitioner	4,716	0	4,716	152,636	157,352	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	1,407	0	1,407	0	1,407	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	25,049	0	25,049	289,475	314,524	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	50,942	50,942	0	50,942	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	50,942	50,942	0	50,942	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	25,049	50,942	75,991	289,475	365,466	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	24,639	24,639	0	24,639	29.00
30.00	Administrative Costs	473,400	26,222	499,622	-289,475	210,147	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	473,400	50,861	524,261	-289,475	234,786	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	498,449	101,803	600,252	0	600,252	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1324 | Component CCN: 14-8627 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-1 | Date/Time Prepared: 8/31/2023 4:04 pm

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	150,944		1.00
2.00	Physician Assistant	0	4,821		2.00
3.00	Nurse Practitioner	0	157,352		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	1,407		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	314,524		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	50,942		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	50,942		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	365,466		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	24,639		29.00
30.00	Administrative Costs	0	210,147		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	234,786		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	600,252		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1324 | Component CCN: 14-8506 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-2 | Date/Time Prepared: 8/31/2023 4:04 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.32	13,521	4,200	9,744		1.00
2.00	Physician Assistant	0.78	2,882	2,100	1,638		2.00
3.00	Nurse Practitioner	1.16	8,385	2,100	2,436		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.26	24,788		13,818	24,788	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.26	24,788			24,788	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,946,879	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,946,879	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					4,927,173	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,971,387	15.00
16.00	Total overhead (sum of lines 14 and 15)					8,898,560	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					8,898,560	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					8,898,560	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					11,845,439	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 14-1324 | Component CCN: 14-8588 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-2 | Date/Time Prepared: 8/31/2023 4:04 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.76	4,415	4,200	3,192		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.06	7,611	2,100	2,226		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.82	12,026		5,418	12,026	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.82	12,026			12,026	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)					407,386	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					407,386	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,329,774	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					753,287	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,083,061	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,083,061	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,083,061	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,490,447	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1324 | Component CCN: 14-8616 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-2 | Date/Time Prepared: 8/31/2023 4:04 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC III Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.16	962	4,200	672		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.70	5,076	2,100	1,470		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.86	6,038		2,142	6,038	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.86	6,038			6,038	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)					536,282	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					536,282	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					550,255	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					394,510	15.00
16.00	Total overhead (sum of lines 14 and 15)					944,765	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					944,765	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					944,765	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,481,047	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 14-1324 | Component CCN: 14-8627 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-2 | Date/Time Prepared: 8/31/2023 4:04 pm

RHC IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.32	1,860	4,200	1,344		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.41	2,932	2,100	861		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.73	4,792		2,205	4,792	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.73	4,792			4,792	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)					365,466	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					365,466	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					234,786	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					285,780	15.00
16.00	Total overhead (sum of lines 14 and 15)					520,566	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					520,566	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					520,566	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					886,032	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1324 Component CCN: 14-8506	Period: From 04/01/2022 To 03/31/2023	Worksheet M-3 Date/Time Prepared: 8/31/2023 4:04 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			11,845,439	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			478,411	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			11,367,028	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			24,788	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)			24,788	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			458.57	7.00
		Calculation of Limit (1)			
		Rate Period 1 (04/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 03/31/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	271.52	281.83		8.00
9.00	Rate for Program covered visits (see instructions)	271.52	281.83		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	7,714	2,572		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	2,094,505	724,867		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	2,819,372		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,758,671		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0		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.)		2,131,744		16.04
16.05	Total program cost (see instructions)	0	2,131,744		16.05
17.00	Primary payer amounts		349		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		154,692		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		319,024		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		2,131,395		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		323,564		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		2,454,959		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		2,454,959		26.00
26.01	Sequestration adjustment (see instructions)		42,961		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		2,089,112		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)		322,886		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1324 Component CCN: 14-8588	Period: From 04/01/2022 To 03/31/2023	Worksheet M-3 Date/Time Prepared: 8/31/2023 4:04 pm
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,490,447	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		240,239	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		2,250,208	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		12,026	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)		12,026	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		187.11	7.00

		Calculation of Limit (1)		
		Rate Period 1 (04/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 03/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	165.91	171.04	8.00
9.00	Rate for Program covered visits (see instructions)	165.91	171.04	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	2,894	965	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	480,144	165,054	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	645,198	16.00
16.01	Total program charges (see instructions)(from contractor's records)		717,293	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	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.)		460,758	16.04
16.05	Total program cost (see instructions)	0	460,758	16.05
17.00	Primary payer amounts		242	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		69,251	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		128,961	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		460,516	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		165,948	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		626,464	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		626,464	26.00
26.01	Sequestration adjustment (see instructions)		10,963	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		435,956	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)		179,545	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1324 Component CCN: 14-8616	Period: From 04/01/2022 To 03/31/2023	Worksheet M-3 Date/Time Prepared: 8/31/2023 4:04 pm
	Title XVIII	RHC III	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,481,047	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		101,437	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,379,610	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		6,038	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		6,038	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		228.49	7.00

		Calculation of Limit (1)		
		Rate Period 1 (04/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 03/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	136.49	141.67	8.00
9.00	Rate for Program covered visits (see instructions)	136.49	141.67	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	626	209	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	85,443	29,609	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	115,052	16.00
16.01	Total program charges (see instructions)(from contractor's records)		130,087	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	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.)		75,094	16.04
16.05	Total program cost (see instructions)	0	75,094	16.05
17.00	Primary payer amounts		34	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		21,185	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		21,477	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		75,060	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		31,234	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		106,294	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		106,294	26.00
26.01	Sequestration adjustment (see instructions)		1,860	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		72,883	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)		31,551	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1324 Component CCN: 14-8627	Period: From 04/01/2022 To 03/31/2023	Worksheet M-3 Date/Time Prepared: 8/31/2023 4:04 pm
	Title XVIII	RHC IV	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)			886,032	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			53,863	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			832,169	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,792	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			4,792	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			173.66	7.00
		Calculation of Limit (1)			
		Rate Period 1 (04/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 03/31/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	113.00	126.00		8.00
9.00	Rate for Program covered visits (see instructions)	113.00	126.00		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	979	326		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	110,627	41,076		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	151,703		16.00
16.01	Total program charges (see instructions)(from contractor's records)		247,805		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0		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.)		88,743		16.04
16.05	Total program cost (see instructions)	0	88,743		16.05
17.00	Primary payer amounts		125		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		40,774		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		40,995		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		88,618		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		41,864		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		130,482		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		130,482		26.00
26.01	Sequestration adjustment (see instructions)		2,283		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		83,288		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)		44,911		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: 14-1324 | Component CCN: 14-8506 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-4 | Date/Time Prepared: 8/31/2023 4:04 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,668,563	2,668,563	2,668,563	2,668,563	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.003002	0.013881	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	8,011	37,042	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	36,350	37,613	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	44,361	74,655	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,946,879	2,946,879	2,946,879	2,946,879	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	8,898,560	8,898,560	8,898,560	8,898,560	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.015054	0.025334	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	133,959	225,436	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	178,320	300,091	0	0	10.00
11.00	Total number of injections/infusions (from your records)	266	1,230	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	670.38	243.98	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	134	958	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)	89,831	233,733	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)		478,411	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)		323,564	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1324 | Component CCN: 14-8588 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-4 | Date/Time Prepared: 8/31/2023 4:04 pm

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	376,373	376,373	376,373	376,373	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.005371	0.019238	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	2,021	7,241	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	16,673	13,363	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	18,694	20,604	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	407,386	407,386	407,386	407,386	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,083,061	2,083,061	2,083,061	2,083,061	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.045888	0.050576	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	95,588	105,353	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	114,282	125,957	0	0	10.00
11.00	Total number of injections/infusions (from your records)	122	437	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	936.74	288.23	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	67	358	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)	62,762	103,186	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)		240,239	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)		165,948	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1324 | Component CCN: 14-8616 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-4 | Date/Time Prepared: 8/31/2023 4:04 pm

Title XVIII | RHC III | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	483,438	483,438	483,438	483,438	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.010958	0.018600	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	5,298	8,992	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	16,263	6,177	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	21,561	15,169	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	536,282	536,282	536,282	536,282	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	944,765	944,765	944,765	944,765	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.040205	0.028285	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	37,984	26,723	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	59,545	41,892	0	0	10.00
11.00	Total number of injections/infusions (from your records)	119	202	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	500.38	207.39	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	16	112	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)	8,006	23,228	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)		101,437	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)		31,234	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1324 | Component CCN: 14-8627 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-4 | Date/Time Prepared: 8/31/2023 4:04 pm

Title XVIII | RHC IV | 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)	314,524	314,524	314,524	314,524	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.003900	0.026355	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,227	8,289	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	5,056	7,645	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	6,283	15,934	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	365,466	365,466	365,466	365,466	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	520,566	520,566	520,566	520,566	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.017192	0.043599	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	8,950	22,696	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	15,233	38,630	0	0	10.00
11.00	Total number of injections/infusions (from your records)	37	250	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	411.70	154.52	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	30	191	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)	12,351	29,513	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)		53,863	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)		41,864	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1324 Component CCN: 14-8506	Period: From 04/01/2022 To 03/31/2023	Worksheet M-5 Date/Time Prepared: 8/31/2023 4:04 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		2,094,626	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		10/19/2022	5,514	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)		-5,514	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		2,089,112	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		322,886	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		2,411,998	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1324 Component CCN: 14-8588	Period: From 04/01/2022 To 03/31/2023	Worksheet M-5 Date/Time Prepared: 8/31/2023 4:04 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		377,065	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		10/19/2022	58,891	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)		58,891	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		435,956	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		179,545	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		615,501	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1324 Component CCN: 14-8616	Period: From 04/01/2022 To 03/31/2023	Worksheet M-5 Date/Time Prepared: 8/31/2023 4:04 pm
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		72,228	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		10/19/2022	655	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)		655	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		72,883	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		31,551	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		104,434	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1324 Component CCN: 14-8627	Period: From 04/01/2022 To 03/31/2023	Worksheet M-5 Date/Time Prepared: 8/31/2023 4:04 pm
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		72,281	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		10/19/2022	11,007	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)		11,007	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		83,288	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		44,911	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		128,199	7.00

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