Health Financial Systems | MEMORIAL HOSPITAL ASSOCIATION | In Lieu of Form CMS-2552-10

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: 14-1305	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/17/2024 2:15 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: — Time:
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 PROVIDE 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 MEMORIAL HOSPITAL ASSOCIATION (14-1305) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 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	Teresa Smith		X	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	Teresa Smith			2
3	Signatory Title	CFO			3
4	Date	5/20/24			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	161,892	-390,142	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	-439,485	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		161,240		0	10.00
200.00	TOTAL	0	-277,593	-228,902	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: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/17/2024 2:15 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: SOUTH ADAMS STREET	PO Box: 160			1.00
2.00	City: CARTHAGE	State: IL	Zip Code: 62321-	County: HANCOCK	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	MEMORIAL HOSPITAL ASSOCIATION	141305	99914	1	08/08/2000	N	O	P	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	MEMORIAL HOSPITAL	14Z305	99914		08/08/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	BOWEN CLINIC	143456	99914		02/05/1999	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	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	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/17/2024 2:15 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 St	Date of Geogra	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

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

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

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

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

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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

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				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

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

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		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/17/2024 2:15 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	401,762	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.	Y		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	5.01	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	Y	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	H55770	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: UNITYPOINT HEALTH (IA HEALTH SYSTEM)	Contractor's Name: WPS	Contractor's Number: 05001	141.00
142.00	Street: 1776 WEST LAKES PARKWAY SUITE 400	PO Box:		142.00
143.00	City: WEST DES MOINES	State: IA	Zip Code: 50266-8239	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: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/17/2024 2:15 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: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/17/2024 2:15 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	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	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	03/30/2024	Y	03/30/2024	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/17/2024 2:15 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	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	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.	Y	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TERESA	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer	MEMORIAL HOSPITAL ASSOCIATION		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-357-8564	TSMITH@MHTLC.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1305	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/17/2024 2:15 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CHIEF FINANCIAL OFFICER		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

HFS Supplemental Information | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part IX | Date/Time Prepared: 5/17/2024 2:15 pm

		Title V	Title XIX	
		1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE			
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
3.02	Does Title XIX transfer managed care (HMO) days from Worksheet S-3, Part I, column 7, sum of lines 2, 3, and 4 to Worksheet E-4, column 2, line 26?		Y	3.02
		Inpatient	Outpatient	
		1.00	2.00	
	CRITICAL ACCESS HOSPITALS			
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
	RCE DISALLOWANCE			
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	Y	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	N	N	7.00
	RHC			
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
	FQHC			
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00
		State		
		1.00		
	STATE MEDICAID FORMS			
10.00	Select the state when using state Medicaid forms.			10.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/17/2024 2:15 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	18	6,570	38,760.00	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)		18	6,570	38,760.00	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	43.00				0	13.00
14.00	Total (see instructions)		18	6,570	38,760.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		18				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: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/17/2024 2:15 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)	1,062	89	1,615			1.00
2.00	HMO and other (see instructions)	293	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	704	0	748			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	14			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,766	89	2,377			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		0	0			13.00
14.00	Total (see instructions)	1,766	89	2,377	0.00	195.77	14.00
15.00	CAH visits	10,987	5,927	28,924			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	8,457	12,880	44,181	0.00	79.41	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	275.18	27.00
28.00	Observation Bed Days		109	655			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: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/17/2024 2:15 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	302	18	442	1.00
2.00	HMO and other (see instructions)			69	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	302	18	442	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1305 | Component CCN: 14-3456 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/17/2024 2:15 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street					1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County			IL		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
9.01						9.01
9.02						9.02
9.03						9.03
9.04						9.04
9.05						9.05
9.06						9.06
9.07						9.07
9.08						9.08
9.09						9.09
9.10						9.10
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			08:00	17:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				Y	6	13.00
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.				N	0	13.01
				Provider name		CCN	
				1.00		2.00	
14.00	RHC/FQHC name, CCN			BOWEN CLINIC		143456	14.00
14.01				WOMEN & FAMILY MEDICAL GROUP CLINIC		143405	14.01
14.02				LAHARPE CLINIC		148534	14.02
14.03				NAUVOO CLINIC		148547	14.03
14.04				CARTHAGE CLINIC		148571	14.04
14.05				COLCHESTER CLINIC		148572	14.05

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1305 Component CCN: 14-3456	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/17/2024 2:15 pm

					RHC I	Cost	
		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		HANCOCK				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	18:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:00	08:00	14:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/17/2024 2:15 pm

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.396821	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,679,433	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	21,957,275	6.00
7.00	Medicaid cost (line 1 times line 6)	8,713,108	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	1,033,675	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,033,675	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	112,264	851,357	963,621	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	44,549	851,357	895,906	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,723	9,657	11,380	22.00
23.00	Cost of charity care (see instructions)	42,826	841,700	884,526	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	1,939,432	26.00
27.00	Medicare reimbursable bad debts (see instructions)	233,612	27.00
27.01	Medicare allowable bad debts (see instructions)	359,403	27.01
28.00	Non-Medicare bad debt amount (see instructions)	1,580,029	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	752,780	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,637,306	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,670,981	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1305	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/17/2024 3:43 pm

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)		1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		5.00
6.00	Medicaid charges		6.00
7.00	Medicaid cost (line 1 times line 6)		7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP		9.00
10.00	Stand-alone CHIP charges		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)				20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)				21.00
22.00	Payments received from patients for amounts previously written off as charity care				22.00
23.00	Cost of charity care (see instructions)				23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		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		25.00
25.01	Charges for insured patients' liability (see instructions)		25.01
26.00	Bad debt amount (see instructions)		26.00
27.00	Medicare reimbursable bad debts (see instructions)		27.00
27.01	Medicare allowable bad debts (see instructions)		27.01
28.00	Non-Medicare bad debt amount (see instructions)		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/17/2024 2:15 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	NEW CAP REL COSTS-BLDG & FIXT		1,352,633	1,352,633	-1,322,481	30,152	1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B		0	0	1,577,808	1,577,808	1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB		0	0	358,524	358,524	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,032,375	1,032,375	-1,435	1,030,940	2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP		0	0	21,956	21,956	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	298,389	5,012,335	5,310,724	7,313	5,318,037	4.00
5.01	00550	ADMINISTRATION & GENERAL	3,231,552	4,006,804	7,238,356	276,486	7,514,842	5.01
7.00	00700	OPERATION OF PLANT	306,106	625,227	931,333	919	932,252	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	0	44,181	44,181	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	206,057	206,057	0	206,057	8.00
9.00	00900	HOUSEKEEPING	406,159	74,750	480,909	0	480,909	9.00
10.00	01000	DIETARY	349,734	189,476	539,210	-261,939	277,271	10.00
11.00	01100	CAFETERIA	0	0	0	303,854	303,854	11.00
13.00	01300	NURSING ADMINISTRATION	8,027	10,404	18,431	109,285	127,716	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	371,375	18,952	390,327	2,266	392,593	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	61,914	61,914	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	606,335	54,675	661,010	0	661,010	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,583,597	1,106,539	2,690,136	-92,072	2,598,064	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	627,925	1,297,398	1,925,323	-97,913	1,827,410	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	45,526	45,526	0	45,526	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	903,559	889,572	1,793,131	-89,249	1,703,882	54.00
56.00	05600	RADIOISOTOPE	0	140,628	140,628	0	140,628	56.00
60.00	06000	LABORATORY	1,132,246	1,237,866	2,370,112	42,719	2,412,831	60.00
60.02	06002	GERO PSYCH	0	565,116	565,116	0	565,116	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	79,194	79,194	0	79,194	62.00
65.00	06500	RESPIRATORY THERAPY	454,847	105,982	560,829	-101,373	459,456	65.00
66.00	06600	PHYSICAL THERAPY	318,073	5,314	323,387	12,001	335,388	66.00
69.00	06900	ELECTROCARDIOLOGY	0	43,484	43,484	118,534	162,018	69.00
69.01	06901	PULMONARY REHAB	55,456	780	56,236	2,092	58,328	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	54,700	23,074	77,774	0	77,774	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	454,214	454,214	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	268,422	1,134,398	1,402,820	33,924	1,436,744	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,269,168	1,376,028	9,645,196	-913,778	8,731,418	88.00
90.00	09000	CLINIC	826	681,648	682,474	-7,684	674,790	90.00
91.00	09100	EMERGENCY	707,275	2,804,744	3,512,019	-5,996	3,506,023	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OP NURSING	76,101	9,751	85,852	0	85,852	93.00
93.01	04950	DIABETIC EDUCATION	319,937	36,165	356,102	-120,201	235,901	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		625,963	625,963	-625,963	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,349,809	24,792,858	45,142,667	-212,094	44,930,573	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	1,799,763	613,978	2,413,741	178,341	2,592,082	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	18,160	38,218	56,378	33,753	90,131	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	22,167,732	25,445,054	47,612,786	0	47,612,786	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/17/2024 2:15 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	30,152		1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	-157,430	1,420,378		1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	-50,225	308,299		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-1,934	1,029,006		2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	0	21,956		2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,480	5,334,517		4.00
5.01	00550	ADMINISTRATION & GENERAL	-401,505	7,113,337		5.01
7.00	00700	OPERATION OF PLANT	0	932,252		7.00
7.01	00701	OPERATION OF PLANT MOB	0	44,181		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	206,057		8.00
9.00	00900	HOUSEKEEPING	0	480,909		9.00
10.00	01000	DIETARY	-608	276,663		10.00
11.00	01100	CAFETERIA	-111,318	192,536		11.00
13.00	01300	NURSING ADMINISTRATION	0	127,716		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,339	386,254		16.00
17.00	01700	SOCIAL SERVICE	0	61,914		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-661,010	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-10,455	2,587,609		30.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-371,784	1,455,626		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	45,526		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,703,882		54.00
56.00	05600	RADIOISOTOPE	0	140,628		56.00
60.00	06000	LABORATORY	0	2,412,831		60.00
60.02	06002	GERO PSYCH	-59,119	505,997		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	79,194		62.00
65.00	06500	RESPIRATORY THERAPY	0	459,456		65.00
66.00	06600	PHYSICAL THERAPY	0	335,388		66.00
69.00	06900	ELECTROCARDIOLOGY	0	162,018		69.00
69.01	06901	PULMONARY REHAB	0	58,328		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	77,774		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	454,214		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-266,178	1,170,566		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-78,989	8,652,429		88.00
90.00	09000	CLINIC	-642,020	32,770		90.00
91.00	09100	EMERGENCY	-948,787	2,557,236		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OP NURSING	0	85,852		93.00
93.01	04950	DIABETIC EDUCATION	-10,263	225,638		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,761,484	41,169,089		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,592,082		192.00
194.00	07950	NAUVOO APARTMENTS	0	0		194.00
194.01	07952	FITNESS CENTER	0	90,131		194.01
194.02	07951	BEAUTY SHOP	0	0		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,761,484	43,851,302		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet Non-CMS Wo | Date/Time Prepared: 5/17/2024 2:15 pm

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	00102		1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	00103		1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	00201		2.01
3.00	OTHER CAPITAL RELATED COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01	ADMINISTRATION & GENERAL	00550	DATA PROCESSING	5.01
7.00	OPERATION OF PLANT	00700		7.00
7.01	OPERATION OF PLANT MOB	00701		7.01
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
43.00	NURSERY	04300		43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00	RADIOISOTOPE	05600		56.00
60.00	LABORATORY	06000		60.00
60.02	GERO PSYCH	06002		60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	06200		62.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
69.00	ELECTROCARDIOLOGY	06900		69.00
69.01	PULMONARY REHAB	06901		69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	08800		88.00
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
93.00	OP NURSING	04040	FAMILY PRACTICE	93.00
93.01	DIABETIC EDUCATION	04950		93.01
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	09500		95.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
194.00	NAUVOO APARTMENTS	07950		194.00
194.01	FITNESS CENTER	07952		194.01
194.02	BEAUTY SHOP	07951		194.02
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/17/2024 2:15 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS DEPRECIATION EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1,031,884		1.00
2.00	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	253,022		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	39,509		3.00
	TOTALS		0	1,324,415		
	B - TO RECLASS CAFETERIA					
1.00	CAFETERIA	11.00	197,081	106,773		1.00
	TOTALS		197,081	106,773		
	D - TO RECLASS SOCIAL SERVICES SALARY					
1.00	SOCIAL SERVICE	17.00	61,914	0		1.00
	TOTALS		61,914	0		
	E - TO RECLASS INTEREST					
1.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	519,522		1.00
2.00	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	99,701		2.00
3.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	6,740		3.00
	TOTALS		0	625,963		
	G - MOB EQUIPMENT DEPRECIATION					
1.00	CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	21,421		1.00
	TOTALS		0	21,421		
	H - TO RECLASS EKG TIME					
1.00	ELECTROCARDIOLOGY	69.00	121,946	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	3,412		2.00
	TOTALS		121,946	3,412		
	I - TO RECLASS NON RHC TIME					
1.00	OPERATING ROOM	50.00	328,857	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	10,455	0		2.00
	TOTALS		339,312	0		
	K - RECLASS ALLOWABLE PHYSICIAN FICA					
1.00	OPERATING ROOM	50.00	0	23,975		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	762		2.00
	TOTALS		0	24,737		
	M - IMPLANTABLE SUPPLIES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	454,214		1.00
	TOTALS		0	454,214		
	N - SPECIALTY DRUGS RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	23,797		1.00
	TOTALS		0	23,797		
	Q - CARE COORDINATION AND ADMIN TIME					
1.00	ADMINISTRATION & GENERAL	5.01	373,771	0		1.00
	TOTALS		373,771	0		
	R - DR PERLL INSURANCE					
1.00	RURAL HEALTH CLINIC	88.00	0	26,382		1.00
	TOTALS		0	26,382		
	S - INDEPENDENT CLINIC SALARIES					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	271,508	0		1.00
	TOTALS		271,508	0		
	T - DIETICIAN SERVICES					
1.00	DIETARY	10.00	41,915	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	5,012	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	3,997	0		3.00
4.00	RURAL HEALTH CLINIC	88.00	3,474	0		4.00
5.00	FITNESS CENTER	194.01	33,753	0		5.00
6.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	32,050	0		6.00
	TOTALS		120,201	0		
	U - PROF LIAB INSURANCE					
1.00	OPERATING ROOM	50.00	0	29,851		1.00
	TOTALS		0	29,851		
	V - RHC SALARIES					
1.00	RURAL HEALTH CLINIC	88.00	40,603	0		1.00
	TOTALS		40,603	0		
	W - PROPERTY INSURANCE					
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	47,918		1.00
	TOTALS		0	47,918		
	X - LOCUST ST RECEPTIONIST & UTILITIES					
1.00	ADMINISTRATION & GENERAL	5.01	0	7,398		1.00
2.00	OPERATION OF PLANT	7.00	0	919		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,266		3.00
4.00	RURAL HEALTH CLINIC	88.00	37,632	4,349		4.00
	TOTALS		37,632	14,932		

RECLASSIFICATIONS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/17/2024 2:15 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	Y - CARTHAGE MOB UTILITIES					
1.00	OPERATION OF PLANT MOB	7.01	0	44,181		1.00
	TOTALS		0	44,181		
	Z - PROVIDER BASED CLINIC SALARIES					
1.00	CLINIC	90.00	16,113	0		1.00
	TOTALS		16,113	0		
	AA - CHIEF ANCILLARY OFFICER					
1.00	ADMINISTRATION & GENERAL	5.01	5,149	0		1.00
2.00	LABORATORY	60.00	42,719	0		2.00
3.00	RESPIRATORY THERAPY	65.00	17,161	0		3.00
4.00	PHYSICAL THERAPY	66.00	12,001	0		4.00
5.00	PULMONARY REHAB	69.01	2,092	0		5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	10,127	0		6.00
	TOTALS		89,249	0		
	AB - CNO SALARIES					
1.00	NURSING ADMINISTRATION	13.00	109,285	0		1.00
	TOTALS		109,285	0		
	AC - ACUTE PORTION OF AMBULANCE TRANSFERS					
1.00	ADULTS & PEDIATRICS	30.00	0	5,996		1.00
	TOTALS		0	5,996		
500.00	Grand Total: Increases		1,778,615	2,753,992		500.00

RECLASSIFICATIONS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/17/2024 2:15 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS DEPRECIATION EXPENSE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,324,415	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
	TOTALS		0	1,324,415			
	B - TO RECLASS CAFETERIA						
1.00	DIETARY	10.00	197,081	106,773	0		1.00
	TOTALS		197,081	106,773			
	D - TO RECLASS SOCIAL SERVICES SALARY						
1.00	ADMINISTRATION & GENERAL	5.01	61,914	0	0		1.00
	TOTALS		61,914	0			
	E - TO RECLASS INTEREST						
1.00	INTEREST EXPENSE	113.00	0	625,963	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
	TOTALS		0	625,963			
	G - MOB EQUIPMENT DEPRECIATION						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	21,421	9		1.00
	TOTALS		0	21,421			
	H - TO RECLASS EKG TIME						
1.00	RESPIRATORY THERAPY	65.00	121,946	0	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	3,412	0		2.00
	TOTALS		121,946	3,412			
	I - TO RECLASS NON RHC TIME						
1.00	RURAL HEALTH CLINIC	88.00	339,312	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		339,312	0			
	K - RECLASS ALLOWABLE PHYSICIAN FICA						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	24,737	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	24,737			
	M - IMPLANTABLE SUPPLIES RECLASS						
1.00	OPERATING ROOM	50.00	0	454,214	0		1.00
	TOTALS		0	454,214			
	N - SPECIALTY DRUGS RECLASS						
1.00	CLINIC	90.00	0	23,797	0		1.00
	TOTALS		0	23,797			
	Q - CARE COORDINATION AND ADMIN TIME						
1.00	RURAL HEALTH CLINIC	88.00	373,771	0	0		1.00
	TOTALS		373,771	0			
	R - DR PERLL INSURANCE						
1.00	OPERATING ROOM	50.00	0	26,382	0		1.00
	TOTALS		0	26,382			
	S - INDEPENDENT CLINIC SALARIES						
1.00	RURAL HEALTH CLINIC	88.00	271,508	0	0		1.00
	TOTALS		271,508	0			
	T - DIETICIAN SERVICES						
1.00	DIABETIC EDUCATION	93.01	120,201	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		120,201	0			
	U - PROF LIAB INSURANCE						
1.00	RURAL HEALTH CLINIC	88.00	0	29,851	0		1.00
	TOTALS		0	29,851			
	V - RHC SALARIES						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	40,603	0	0		1.00
	TOTALS		40,603	0			
	W - PROPERTY INSURANCE						
1.00	ADMINISTRATION & GENERAL	5.01	0	47,918	0		1.00
	TOTALS		0	47,918			
	X - LOCUST ST RECEPTIONIST & UTILITIES						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	37,632	14,932	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		37,632	14,932			
	Y - CARTHAGE MOB UTILITIES						
1.00	RURAL HEALTH CLINIC	88.00	0	44,181	0		1.00
	TOTALS		0	44,181			

RECLASSIFICATIONS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/17/2024 2:15 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	Z - PROVIDER BASED CLINIC SALARIES						
1.00	RURAL HEALTH CLINIC	88.00	16,113	0	0		1.00
	TOTALS		16,113	0			
	AA - CHIEF ANCILLARY OFFICER						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	89,249	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		89,249	0			
	AB - CNO SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	109,285	0	0		1.00
	TOTALS		109,285	0			
	AC - ACUTE PORTION OF AMBULANCE TRANSFERS						
1.00	EMERGENCY	91.00	0	5,996	0		1.00
	TOTALS		0	5,996			
500.00	Grand Total: Decreases		1,778,615	2,753,992			500.00

RECLASSIFICATIONS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 5/17/2024 2:15 pm

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - TO RECLASS DEPRECIATION EXPENSE								
1.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1,031,884	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,324,415	1.00
2.00	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	253,022		0.00	0	0	2.00
3.00	RURAL HEALTH CLINIC	88.00	0	39,509		0.00	0	0	3.00
	TOTALS		0	1,324,415	TOTALS		0	1,324,415	
	B - TO RECLASS CAFETERIA								
1.00	CAFETERIA	11.00	197,081	106,773	DIETARY	10.00	197,081	106,773	1.00
	TOTALS		197,081	106,773	TOTALS		197,081	106,773	
	D - TO RECLASS SOCIAL SERVICES SALARY								
1.00	SOCIAL SERVICE	17.00	61,914	0	ADMINISTRATION & GENERAL	5.01	61,914	0	1.00
	TOTALS		61,914	0	TOTALS		61,914	0	
	E - TO RECLASS INTEREST								
1.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	519,522	INTEREST EXPENSE	113.00	0	625,963	1.00
2.00	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	99,701		0.00	0	0	2.00
3.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	6,740		0.00	0	0	3.00
	TOTALS		0	625,963	TOTALS		0	625,963	
	G - MOB EQUIPMENT DEPRECIATION								
1.00	CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	21,421	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	21,421	1.00
	TOTALS		0	21,421	TOTALS		0	21,421	
	H - TO RECLASS EKG TIME								
1.00	ELECTROCARDIOLOGY	69.00	121,946	0	RESPIRATORY THERAPY	65.00	121,946	0	1.00
2.00	RESPIRATORY THERAPY	65.00	0	3,412	ELECTROCARDIOLOGY	69.00	0	3,412	2.00
	TOTALS		121,946	3,412	TOTALS		121,946	3,412	
	I - TO RECLASS NON RHC TIME								
1.00	OPERATING ROOM	50.00	328,857	0	RURAL HEALTH CLINIC	88.00	339,312	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	10,455	0		0.00	0	0	2.00
	TOTALS		339,312	0	TOTALS		339,312	0	
	K - RECLASS ALLOWABLE PHYSICIAN FICA								
1.00	OPERATING ROOM	50.00	0	23,975	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	24,737	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	762		0.00	0	0	2.00
	TOTALS		0	24,737	TOTALS		0	24,737	
	M - IMPLANTABLE SUPPLIES RECLASS								
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	454,214	OPERATING ROOM	50.00	0	454,214	1.00
	TOTALS		0	454,214	TOTALS		0	454,214	
	N - SPECIALTY DRUGS RECLASS								
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	23,797	CLINIC	90.00	0	23,797	1.00
	TOTALS		0	23,797	TOTALS		0	23,797	
	Q - CARE COORDINATION AND ADMIN TIME								
1.00	ADMINISTRATION & GENERAL	5.01	373,771	0	RURAL HEALTH CLINIC	88.00	373,771	0	1.00
	TOTALS		373,771	0	TOTALS		373,771	0	
	R - DR PERLL INSURANCE								
1.00	RURAL HEALTH CLINIC	88.00	0	26,382	OPERATING ROOM	50.00	0	26,382	1.00
	TOTALS		0	26,382	TOTALS		0	26,382	
	S - INDEPENDENT CLINIC SALARIES								
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	271,508	0	RURAL HEALTH CLINIC	88.00	271,508	0	1.00
	TOTALS		271,508	0	TOTALS		271,508	0	
	T - DIETICIAN SERVICES								
1.00	DIETARY	10.00	41,915	0	DIABETIC EDUCATION	93.01	120,201	0	1.00
2.00	RURAL HEALTH CLINIC	88.00	5,012	0		0.00	0	0	2.00
3.00	RURAL HEALTH CLINIC	88.00	3,997	0		0.00	0	0	3.00
4.00	RURAL HEALTH CLINIC	88.00	3,474	0		0.00	0	0	4.00
5.00	FITNESS CENTER	194.01	33,753	0		0.00	0	0	5.00
6.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	32,050	0		0.00	0	0	6.00
	TOTALS		120,201	0	TOTALS		120,201	0	
	U - PROF LIAB INSURANCE								
1.00	OPERATING ROOM	50.00	0	29,851	RURAL HEALTH CLINIC	88.00	0	29,851	1.00
	TOTALS		0	29,851	TOTALS		0	29,851	
	V - RHC SALARIES								
1.00	RURAL HEALTH CLINIC	88.00	40,603	0	PHYSICIANS' PRIVATE OFFICES	192.00	40,603	0	1.00
	TOTALS		40,603	0	TOTALS		40,603	0	

RECLASSIFICATIONS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 5/17/2024 2:15 pm

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	W - PROPERTY INSURANCE								
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	47,918	ADMINISTRATION & GENERAL	5.01	0	47,918	1.00
	TOTALS		0	47,918	TOTALS		0	47,918	
	X - LOCUST ST RECEPTIONIST & UTILITIES								
1.00	ADMINISTRATION & GENERAL	5.01	0	7,398	PHYSICIANS' PRIVATE OFFICES	192.00	37,632	14,932	1.00
2.00	OPERATION OF PLANT	7.00	0	919		0.00	0	0	2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,266		0.00	0	0	3.00
4.00	RURAL HEALTH CLINIC	88.00	37,632	4,349		0.00	0	0	4.00
	TOTALS		37,632	14,932	TOTALS		37,632	14,932	
	Y - CARTHAGE MOB UTILITIES								
1.00	OPERATION OF PLANT MOB	7.01	0	44,181	RURAL HEALTH CLINIC	88.00	0	44,181	1.00
	TOTALS		0	44,181	TOTALS		0	44,181	
	Z - PROVIDER BASED CLINIC SALARIES								
1.00	CLINIC	90.00	16,113	0	RURAL HEALTH CLINIC	88.00	16,113	0	1.00
	TOTALS		16,113	0	TOTALS		16,113	0	
	AA - CHIEF ANCILLARY OFFICER								
1.00	ADMINISTRATION & GENERAL	5.01	5,149	0	RADIOLOGY-DIAGNOSTIC	54.00	89,249	0	1.00
2.00	LABORATORY	60.00	42,719	0		0.00	0	0	2.00
3.00	RESPIRATORY THERAPY	65.00	17,161	0		0.00	0	0	3.00
4.00	PHYSICAL THERAPY	66.00	12,001	0		0.00	0	0	4.00
5.00	PULMONARY REHAB	69.01	2,092	0		0.00	0	0	5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	10,127	0		0.00	0	0	6.00
	TOTALS		89,249	0	TOTALS		89,249	0	
	AB - CNO SALARIES								
1.00	NURSING ADMINISTRATION	13.00	109,285	0	ADULTS & PEDIATRICS	30.00	109,285	0	1.00
	TOTALS		109,285	0	TOTALS		109,285	0	
	AC - ACUTE PORTION OF AMBULANCE TRANSFERS								
1.00	ADULTS & PEDIATRICS	30.00	0	5,996	EMERGENCY	91.00	0	5,996	1.00
	TOTALS		0	5,996	TOTALS		0	5,996	
500.00	Grand Total: Increases		1,778,615	2,753,992	Grand Total: Decreases		1,778,615	2,753,992	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/17/2024 2:15 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	514,957	0	0	0	0	1.00
2.00	Land Improvements	1,407,947	5,000	0	5,000	0	2.00
3.00	Buildings and Fixtures	28,049,119	2,210,861	0	2,210,861	248,137	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	10,086,050	1,462,234	0	1,462,234	622,208	6.00
7.00	HIT designated Assets	1,968,769	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	42,026,842	3,678,095	0	3,678,095	870,345	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	42,026,842	3,678,095	0	3,678,095	870,345	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	514,957	0	1.00
2.00	Land Improvements	1,412,947	0	2.00
3.00	Buildings and Fixtures	30,011,843	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	10,926,076	0	6.00
7.00	HIT designated Assets	1,968,769	0	7.00
8.00	Subtotal (sum of lines 1-7)	44,834,592	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	44,834,592	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/17/2024 2:15 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	NEW CAP REL COSTS-BLDG & FIXT	1,352,633	0	0	0	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	0	0	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,032,375	0	0	0	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,385,008	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	NEW CAP REL COSTS-BLDG & FIXT	0	1,352,633		1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0		1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0		1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,032,375		2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0		2.01
3.00	Total (sum of lines 1-2)	0	2,385,008		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 5/17/2024 2:15 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	NEW CAP REL COSTS-BLDG & FIXT	1,809,283	0	1,809,283	0.040355	1,934	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	24,702,617	0	24,702,617	0.550972	26,402	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	5,427,847	0	5,427,847	0.121064	5,801	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	12,394,115	0	12,394,115	0.276441	13,246	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	500,730	0	500,730	0.011168	535	2.01
3.00	Total (sum of lines 1-2)	44,834,592	0	44,834,592	0.000000	47,918	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	1,934	28,218	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	26,402	882,832	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0	5,801	224,418	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	13,246	1,009,020	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	535	21,421	0	2.01
3.00	Total (sum of lines 1-2)	0	0	47,918	2,165,909	0	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	NEW CAP REL COSTS-BLDG & FIXT	0	1,934	0	0	30,152	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	511,144	26,402	0	0	1,420,378	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	78,080	5,801	0	0	308,299	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	6,740	13,246	0	0	1,029,006	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	535	0	0	21,956	2.01
3.00	Total (sum of lines 1-2)	595,964	47,918	0	0	2,809,791	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/17/2024 2:15 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.02	Investment income - NEW CAP REL COSTS-BLDG & FIXT (NEW B (chapter 2)	B	-149,052	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	9	1.02
1.03	Investment income - CAP REL COSTS-BLDG & FIXT MOB (chapter 2)	B	-28,604	CAP REL COSTS-BLDG & FIXT MOB	1.03	9	1.03
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-1,934	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	2.00
2.01	Investment income - CAP REL COSTS-MOB MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-854	ADMINISTRATION & GENERAL	5.01	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,877,169			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	1,066,310			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-111,318	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6,339	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-608	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.02	Depreciation - NEW CAP REL COSTS-BLDG & FIXT (NEW B		0	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	26.02
26.03	Depreciation - CAP REL COSTS-BLDG & FIXT MOB		0	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	26.03
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - CAP REL COSTS-MOB MVBLE EQUIP		0	CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	27.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/17/2024 2:15 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	
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	A	0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	AMBULANCE SUBSIDY	A	-193,023	EMERGENCY	91.00	0	33.00
35.00	IT MISC REVENUE	B	0	ADMINISTRATION & GENERAL	5.01	0	35.00
36.00	LOBBYING	A	-9,724	ADMINISTRATION & GENERAL	5.01	0	36.00
39.00	ADVERTISING - HOSPITAL	A	-159,704	ADMINISTRATION & GENERAL	5.01	0	39.00
40.00	ADVERTSING- RHC	A	-23,949	RURAL HEALTH CLINIC	88.00	0	40.00
44.00	UNNECESSARY BORROWING -HOSPITAL	A	-8,378	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	11	44.00
45.00	CLINIC SALARY REIMBURSEMENT	B	-18,526	RURAL HEALTH CLINIC	88.00	0	45.00
45.01	CRNA SALARIES	A	-606,335	NONPHYSICIAN ANESTHETISTS	19.00	0	45.01
45.02	CRNA OTHER EXPENSES	A	-54,675	NONPHYSICIAN ANESTHETISTS	19.00	0	45.02
45.03	PROVIDER TAX	A	-805,846	ADMINISTRATION & GENERAL	5.01	0	45.03
45.04	MISC INCOME	B	-8,651	ADMINISTRATION & GENERAL	5.01	0	45.04
45.05	UNNECESSARY BORROWING - MOB	A	-21,621	CAP REL COSTS-BLDG & FIXT MOB	1.03	11	45.05
45.06	PHYSICIAN RECRUITMENT	A	-10,904	ADMINISTRATION & GENERAL	5.01	0	45.06
45.07	CRNA BENEFITS	A	-18,661	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.07
45.08	PURCHASE DISCOUNTS	B	-32,590	ADMINISTRATION & GENERAL	5.01	0	45.08
45.09	BEHAVIORAL HEALTH RENTAL INCOME	B	-7,300	RURAL HEALTH CLINIC	88.00	0	45.09
45.10	MARKETING SALARIES	A	-83,187	ADMINISTRATION & GENERAL	5.01	0	45.10
45.11	MARKETING BENEFITS	A	-30,385	ADMINISTRATION & GENERAL	5.01	0	45.11
45.12	FOUNDATION SALARIES	A	-170,387	ADMINISTRATION & GENERAL	5.01	0	45.12
45.13	FOUNDATION EXPENSES	A	-44,145	ADMINISTRATION & GENERAL	5.01	0	45.13
45.14	340B PHARMACY	A	-266,178	DRUGS CHARGED TO PATIENTS	73.00	0	45.14
45.15	H&W EDUCATION MISC REV	B	-10,263	DIABETIC EDUCATION	93.01	0	45.15
45.16	DERMATOLOGY MISC REV	B	-29,214	RURAL HEALTH CLINIC	88.00	0	45.16
45.17	FOUNDATION BENEFITS	A	-35,459	ADMINISTRATION & GENERAL	5.01	0	45.17
45.18	PROPERTY TAX - FARM LAND	A	-75,979	ADMINISTRATION & GENERAL	5.01	0	45.18
45.19	EMPLOYEE DAYCARE	A	73,168	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,761,484				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: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/17/2024 2:15 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.01	ADMINISTRATION & GENERAL	MANAGEMENT FEES	0	13,628	1.00
2.00	5.01	ADMINISTRATION & GENERAL	PURCHASED SERVICES	0	435,219	2.00
3.00	5.01	ADMINISTRATION & GENERAL	HOME OFFICE ALLOCATION	1,515,157	0	3.00
4.00	0.00			0	0	4.00
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,515,157	448,847	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	UNITYPOINT HEAL	100.00	UNITYPOINT HEAL	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(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: 14-1305	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/17/2024 2:15 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	-13,628	0		1.00
2.00	-435,219	0		2.00
3.00	1,515,157	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
5.00	1,066,310			5.00

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

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

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

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

6.00	HEALTH SYSTEM		6.00
7.00			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: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/17/2024 2:15 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	20,000	0	20,000	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	10,455	10,455	0	0	0	2.00
3.00	60.02	GERO PSYCH	59,119	59,119	0	0	0	3.00
4.00	50.00	OPERATING ROOM	371,784	371,784	0	0	0	4.00
5.00	90.00	CLINIC	642,020	642,020	0	0	0	5.00
6.00	91.00	EMERGENCY	2,341,547	755,764	1,585,783	0	0	6.00
7.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	38,027	38,027	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			3,482,952	1,877,169	1,605,783		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	60.02	GERO PSYCH	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	10,455		2.00
3.00	60.02	GERO PSYCH	0	0	0	59,119		3.00
4.00	50.00	OPERATING ROOM	0	0	0	371,784		4.00
5.00	90.00	CLINIC	0	0	0	642,020		5.00
6.00	91.00	EMERGENCY	0	0	0	755,764		6.00
7.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	38,027		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	1,877,169		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/17/2024 2:15 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					7	1.00
2.00	Line 1 multiplied by 15 hours per week					105	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					6.55	7.00
8.00	Optional travel expense rate per mile					0.66	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	31.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	88.44	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)	44.22	44.22	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)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					2,764	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)					2,764	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)					2,764	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)					88.45	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					9,287	22.00
23.00	Total salary equivalency (see instructions)					9,287	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
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/17/2024 2:15 pm

Speech Pathology — Cost

		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)	88.44	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)	9,287	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)	9,287	63.00
64.00	Total cost of outside supplier services (from your records)	2,969	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: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/17/2024 2:15 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW BLDG & FIXT (NEW B	BLDG & FIXT MOB	NEW MVBLE EQUIP	
			0	1.00	1.02	1.03	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	30,152	30,152				1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1,420,378	0	1,420,378			1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	308,299	0	0	308,299		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,029,006				1,029,006	2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	21,956				0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,334,517	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	7,113,337	10,612	456,867	104,452	335,413	5.01
7.00	00700	OPERATION OF PLANT	932,252	1,319	60,797	0	44,182	7.00
7.01	00701	OPERATION OF PLANT MOB	44,181	0	0	6,302	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	206,057	0	5,144	0	3,197	8.00
9.00	00900	HOUSEKEEPING	480,909	0	15,489	2,479	9,627	9.00
10.00	01000	DIETARY	276,663	0	26,964	0	16,759	10.00
11.00	01100	CAFETERIA	192,536	0	13,878	0	8,626	11.00
13.00	01300	NURSING ADMINISTRATION	127,716	0	7,490	0	4,655	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	386,254	3,250	22,244	0	29,583	16.00
17.00	01700	SOCIAL SERVICE	61,914	0	4,946	0	3,074	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,587,609	0	276,484	0	171,844	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,455,626	0	119,531	0	74,292	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	45,526	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,703,882	0	125,184	0	77,806	54.00
56.00	05600	RADIOISOTOPE	140,628	0	8,762	0	5,446	56.00
60.00	06000	LABORATORY	2,412,831	0	47,711	0	29,654	60.00
60.02	06002	GERO PSYCH	505,997	0	0	11,987	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	79,194	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	459,456	0	19,531	0	12,139	65.00
66.00	06600	PHYSICAL THERAPY	335,388	0	7,321	0	4,550	66.00
69.00	06900	ELECTROCARDIOLOGY	162,018	0	43,556	0	27,071	69.00
69.01	06901	PULMONARY REHAB	58,328	0	0	11,851	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	77,774	0	9,214	0	5,727	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	454,214	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,170,566	0	35,359	0	21,977	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,652,429	6,239	0	115,179	30,251	88.00
90.00	09000	CLINIC	32,770	0	0	6,240	0	90.00
91.00	09100	EMERGENCY	2,557,236	0	52,346	0	32,535	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OP NURSING	85,852	0	25,127	0	15,617	93.00
93.01	04950	DIABETIC EDUCATION	225,638	0	34,341	0	21,344	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,169,089	21,420	1,418,286	258,490	985,369	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,092	0	1,300	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,592,082	8,732	0	49,809	42,337	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	90,131	0	0	0	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	43,851,302	30,152	1,420,378	308,299	1,029,006	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/17/2024 2:15 pm

		Cost Center Description	CAPITAL RELATED COSTS MOB MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATION & GENERAL	OPERATION OF PLANT	
			2.01	4.00	4A	5.01	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	21,956					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,334,517				4.00
5.01	00550	ADMINISTRATION & GENERAL	7,439	906,096	8,934,216	8,934,216		5.01
7.00	00700	OPERATION OF PLANT	0	78,162	1,116,712	285,732	1,402,444	7.00
7.01	00701	OPERATION OF PLANT MOB	449	0	50,932	13,032	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	214,398	54,858	7,992	8.00
9.00	00900	HOUSEKEEPING	177	103,709	612,390	156,692	24,063	9.00
10.00	01000	DIETARY	0	49,681	370,067	94,689	41,892	10.00
11.00	01100	CAFETERIA	0	50,323	265,363	67,898	21,561	11.00
13.00	01300	NURSING ADMINISTRATION	0	29,955	169,816	43,451	11,637	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	94,828	536,159	137,186	34,558	16.00
17.00	01700	SOCIAL SERVICE	0	15,809	85,743	21,939	7,685	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	376,454	3,412,391	873,125	429,540	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	160,336	1,809,785	463,068	185,702	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	45,526	11,649	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	207,928	2,114,800	541,112	194,484	54.00
56.00	05600	RADIOISOTOPE	0	0	154,836	39,618	13,613	56.00
60.00	06000	LABORATORY	0	300,018	2,790,214	713,929	74,123	60.00
60.02	06002	GERO PSYCH	854	0	518,838	132,755	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	79,194	20,263	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	89,386	580,512	148,535	30,343	65.00
66.00	06600	PHYSICAL THERAPY	0	84,282	431,541	110,418	11,373	66.00
69.00	06900	ELECTROCARDIOLOGY	0	31,138	263,783	67,494	67,668	69.00
69.01	06901	PULMONARY REHAB	844	14,694	85,717	21,932	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,967	106,682	27,297	14,315	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	454,214	116,219	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	71,125	1,299,027	332,381	54,933	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,202	1,879,109	10,691,409	2,735,614	0	88.00
90.00	09000	CLINIC	444	4,325	43,779	11,202	0	90.00
91.00	09100	EMERGENCY	0	180,597	2,822,714	722,245	81,324	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	04040	OP NURSING	0	19,432	146,028	37,364	39,037	93.00
93.01	04950	DIABETIC EDUCATION	0	51,001	332,324	85,031	53,352	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,409	4,812,355	40,539,110	8,086,728	1,399,195	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,392	868	3,249	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,547	508,906	3,205,413	820,166	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	13,256	103,387	26,454	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,956	5,334,517	43,851,302	8,934,216	1,402,444	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/17/2024 2:15 pm

		Cost Center Description	OPERATION OF PLANT MOB	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.01	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB	63,964					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	277,248				8.00
9.00	00900	HOUSEKEEPING	803	49,124	843,072			9.00
10.00	01000	DIETARY	0	1,404	15,451	523,503		10.00
11.00	01100	CAFETERIA	0	0	7,952	0	362,774	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	4,292	0	6,400	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	27,274	0	24,718	16.00
17.00	01700	SOCIAL SERVICE	0	0	2,834	0	147	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	97,887	158,427	523,503	59,762	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	78,905	68,492	0	29,707	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,267	71,731	0	37,889	54.00
56.00	05600	RADIOISOTOPE	0	0	5,021	0	0	56.00
60.00	06000	LABORATORY	0	0	27,338	0	53,245	60.00
60.02	06002	GERO PSYCH	3,881	0	15,742	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	549	11,191	0	9,659	65.00
66.00	06600	PHYSICAL THERAPY	0	0	4,195	0	11,325	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	24,958	0	3,538	69.00
69.01	06901	PULMONARY REHAB	3,837	0	15,564	0	3,011	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	5,280	0	3,010	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	20,261	0	6,655	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	37,295	4,269	179,158	0	79,477	88.00
90.00	09000	CLINIC	2,020	0	8,195	0	0	90.00
91.00	09100	EMERGENCY	0	19,666	29,995	0	28,335	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OP NURSING	0	0	14,398	0	2,936	93.00
93.01	04950	DIABETIC EDUCATION	0	0	19,678	0	2,960	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,836	272,071	737,427	523,503	362,774	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1,198	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,128	5,177	104,447	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	63,964	277,248	843,072	523,503	362,774	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/17/2024 2:15 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			13.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	235,596					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	759,895				16.00
17.00	01700	SOCIAL SERVICE	0	0	118,348			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	116,612	51,493	115,981	0	5,838,721	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	57,966	70,632	0	0	2,764,257	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	4,447	0	0	61,622	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	183,311	0	0	3,163,594	54.00
56.00	05600	RADIOISOTOPE	0	5,903	0	0	218,991	56.00
60.00	06000	LABORATORY	0	158,502	0	0	3,817,351	60.00
60.02	06002	GERO PSYCH	0	8,987	0	0	680,203	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	999	0	0	100,456	62.00
65.00	06500	RESPIRATORY THERAPY	0	16,498	0	0	797,287	65.00
66.00	06600	PHYSICAL THERAPY	0	10,708	0	0	579,560	66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,239	0	0	435,680	69.00
69.01	06901	PULMONARY REHAB	0	2,129	0	0	132,190	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,426	0	0	163,010	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,395	0	0	578,828	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	38,217	0	0	1,751,474	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	132,796	0	0	13,860,018	88.00
90.00	09000	CLINIC	0	1,517	0	0	66,713	90.00
91.00	09100	EMERGENCY	55,289	45,797	2,367	0	3,807,732	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OP NURSING	5,729	4,602	0	0	250,094	93.00
93.01	04950	DIABETIC EDUCATION	0	297	0	0	493,642	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	235,596	759,895	118,348	0	39,561,423	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	8,707	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	4,151,331	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	0	129,841	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	235,596	759,895	118,348	0	43,851,302	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/17/2024 2:15 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B				1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB				1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	ADMINISTRATION & GENERAL				5.01
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT MOB				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	5,838,721		30.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,764,257		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	61,622		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,163,594		54.00
56.00	05600	RADIOISOTOPE	0	218,991		56.00
60.00	06000	LABORATORY	0	3,817,351		60.00
60.02	06002	GERO PSYCH	0	680,203		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	100,456		62.00
65.00	06500	RESPIRATORY THERAPY	0	797,287		65.00
66.00	06600	PHYSICAL THERAPY	0	579,560		66.00
69.00	06900	ELECTROCARDIOLOGY	0	435,680		69.00
69.01	06901	PULMONARY REHAB	0	132,190		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	163,010		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	578,828		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,751,474		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	13,860,018		88.00
90.00	09000	CLINIC	0	66,713		90.00
91.00	09100	EMERGENCY	0	3,807,732		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	04040	OP NURSING	0	250,094		93.00
93.01	04950	DIABETIC EDUCATION	0	493,642		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	39,561,423		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,707		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,151,331		192.00
194.00	07950	NAUVOO APARTMENTS	0	0		194.00
194.01	07952	FITNESS CENTER	0	129,841		194.01
194.02	07951	BEAUTY SHOP	0	0		194.02
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	43,851,302		202.00

COST ALLOCATION STATISTICS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet Non-CMS Wo | Date/Time Prepared: 5/17/2024 2:15 pm

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	WFMG/ADMIN SQUARE FEET	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	23	NEW HOSP SQUARE FE	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	1	MOB SQUARE FEET	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	5	HOSP/WFMG/ADMIN SQUARE FEET	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	1	MOB SQUARE FEET	2.01
4.00	EMPLOYEE BENEFITS DEPARTMENT	12	SALARIES	4.00
5.01	ADMINISTRATION & GENERAL	-5	ACCUM. COST	5.01
7.00	OPERATION OF PLANT	10	HOSP ONLY SQUARE FT	7.00
7.01	OPERATION OF PLANT MOB	1	MOB SQUARE FEET	7.01
8.00	LAUNDRY & LINEN SERVICE	11	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	27	NEW HOSP, WFMG/ADMIN, MOB SQFT	9.00
10.00	DIETARY	13	HOSP PATIENT DAYS	10.00
11.00	CAFETERIA	14	HOURS OF SERVICE	11.00
13.00	NURSING ADMINISTRATION	16	DIRECT NRSING HRS	13.00
16.00	MEDICAL RECORDS & LIBRARY	19	GROSS REVENUES	16.00
17.00	SOCIAL SERVICE	20	TIME SPENT	17.00
19.00	NONPHYSICIAN ANESTHETISTS	22	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/17/2024 2:15 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW BLDG & FIXT (NEW B	BLDG & FIXT MOB	NEW MVBLE EQUIP	
			0	1.00	1.02	1.03	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	0	10,612	456,867	104,452	335,413	5.01
7.00	00700	OPERATION OF PLANT	0	1,319	60,797	0	44,182	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	0	6,302	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	5,144	0	3,197	8.00
9.00	00900	HOUSEKEEPING	0	0	15,489	2,479	9,627	9.00
10.00	01000	DIETARY	0	0	26,964	0	16,759	10.00
11.00	01100	CAFETERIA	0	0	13,878	0	8,626	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	7,490	0	4,655	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,250	22,244	0	29,583	16.00
17.00	01700	SOCIAL SERVICE	0	0	4,946	0	3,074	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	276,484	0	171,844	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	119,531	0	74,292	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	125,184	0	77,806	54.00
56.00	05600	RADIOISOTOPE	0	0	8,762	0	5,446	56.00
60.00	06000	LABORATORY	0	0	47,711	0	29,654	60.00
60.02	06002	GERO PSYCH	0	0	0	11,987	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	19,531	0	12,139	65.00
66.00	06600	PHYSICAL THERAPY	0	0	7,321	0	4,550	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	43,556	0	27,071	69.00
69.01	06901	PULMONARY REHAB	0	0	0	11,851	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	9,214	0	5,727	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	35,359	0	21,977	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,239	0	115,179	30,251	88.00
90.00	09000	CLINIC	0	0	0	6,240	0	90.00
91.00	09100	EMERGENCY	0	0	52,346	0	32,535	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OP NURSING	0	0	25,127	0	15,617	93.00
93.01	04950	DIABETIC EDUCATION	0	0	34,341	0	21,344	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	21,420	1,418,286	258,490	985,369	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,092	0	1,300	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,732	0	49,809	42,337	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	30,152	1,420,378	308,299	1,029,006	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/17/2024 2:15 pm

		Cost Center Description	CAPITAL RELATED COSTS MOB MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATION & GENERAL	OPERATION OF PLANT	
			2.01	2A	4.00	5.01	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0			4.00
5.01	00550	ADMINISTRATION & GENERAL	7,439	914,783	0	914,783		5.01
7.00	00700	OPERATION OF PLANT	0	106,298	0	29,257	135,555	7.00
7.01	00701	OPERATION OF PLANT MOB	449	6,751	0	1,334	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,341	0	5,617	772	8.00
9.00	00900	HOUSEKEEPING	177	27,772	0	16,044	2,326	9.00
10.00	01000	DIETARY	0	43,723	0	9,695	4,049	10.00
11.00	01100	CAFETERIA	0	22,504	0	6,952	2,084	11.00
13.00	01300	NURSING ADMINISTRATION	0	12,145	0	4,449	1,125	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	55,077	0	14,047	3,340	16.00
17.00	01700	SOCIAL SERVICE	0	8,020	0	2,246	743	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	448,328	0	89,401	41,519	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	193,823	0	47,415	17,949	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,193	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	202,990	0	55,406	18,798	54.00
56.00	05600	RADIOISOTOPE	0	14,208	0	4,057	1,316	56.00
60.00	06000	LABORATORY	0	77,365	0	73,101	7,164	60.00
60.02	06002	GERO PSYCH	854	12,841	0	13,593	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	2,075	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	31,670	0	15,209	2,933	65.00
66.00	06600	PHYSICAL THERAPY	0	11,871	0	11,306	1,099	66.00
69.00	06900	ELECTROCARDIOLOGY	0	70,627	0	6,911	6,540	69.00
69.01	06901	PULMONARY REHAB	844	12,695	0	2,246	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,941	0	2,795	1,384	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,900	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	57,336	0	34,033	5,310	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,202	159,871	0	280,092	0	88.00
90.00	09000	CLINIC	444	6,684	0	1,147	0	90.00
91.00	09100	EMERGENCY	0	84,881	0	73,952	7,860	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
93.00	04040	OP NURSING	0	40,744	0	3,826	3,773	93.00
93.01	04950	DIABETIC EDUCATION	0	55,685	0	8,707	5,157	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,409	2,701,974	0	828,006	135,241	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,392	0	89	314	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,547	104,425	0	83,979	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	2,709	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,956	2,809,791	0	914,783	135,555	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/17/2024 2:15 pm

		Cost Center Description	OPERATION OF PLANT MOB	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.01	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB	8,085					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,730				8.00
9.00	00900	HOUSEKEEPING	101	2,610	48,853			9.00
10.00	01000	DIETARY	0	75	895	58,437		10.00
11.00	01100	CAFETERIA	0	0	461	0	32,001	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	249	0	565	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,580	0	2,180	16.00
17.00	01700	SOCIAL SERVICE	0	0	164	0	13	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	5,200	9,180	58,437	5,272	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,192	3,969	0	2,621	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,077	4,157	0	3,342	54.00
56.00	05600	RADIOISOTOPE	0	0	291	0	0	56.00
60.00	06000	LABORATORY	0	0	1,584	0	4,697	60.00
60.02	06002	GERO PSYCH	491	0	912	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	29	648	0	852	65.00
66.00	06600	PHYSICAL THERAPY	0	0	243	0	999	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,446	0	312	69.00
69.01	06901	PULMONARY REHAB	485	0	902	0	266	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	306	0	265	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	1,174	0	587	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,714	227	10,384	0	7,010	88.00
90.00	09000	CLINIC	255	0	475	0	0	90.00
91.00	09100	EMERGENCY	0	1,045	1,738	0	2,500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OP NURSING	0	0	834	0	259	93.00
93.01	04950	DIABETIC EDUCATION	0	0	1,140	0	261	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,046	14,455	42,732	58,437	32,001	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	69	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,039	275	6,052	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,085	14,730	48,853	58,437	32,001	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/17/2024 2:15 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			13.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	18,533					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	76,224				16.00
17.00	01700	SOCIAL SERVICE	0	0	11,186			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,173	5,168	10,962		682,640	30.00
43.00	04300	NURSERY	0	0	0		0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,560	7,089	0		281,618	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		0	52.00
53.00	05300	ANESTHESIOLOGY	0	446	0		1,639	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,354	0		304,124	54.00
56.00	05600	RADIOISOTOPE	0	593	0		20,465	56.00
60.00	06000	LABORATORY	0	15,908	0		179,819	60.00
60.02	06002	GERO PSYCH	0	902	0		28,739	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	100	0		2,175	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,656	0		52,997	65.00
66.00	06600	PHYSICAL THERAPY	0	1,075	0		26,593	66.00
69.00	06900	ELECTROCARDIOLOGY	0	827	0		86,663	69.00
69.01	06901	PULMONARY REHAB	0	214	0		16,808	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	645	0		20,336	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	843	0		12,743	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,836	0		102,276	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	13,328	0		475,626	88.00
90.00	09000	CLINIC	0	152	0		8,713	90.00
91.00	09100	EMERGENCY	4,349	4,596	224		181,145	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OP NURSING	451	462	0		50,349	93.00
93.01	04950	DIABETIC EDUCATION	0	30	0		70,980	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0		0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,533	76,224	11,186	0	2,606,448	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		3,864	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		196,770	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0		0	194.00
194.01	07952	FITNESS CENTER	0	0	0		2,709	194.01
194.02	07951	BEAUTY SHOP	0	0	0		0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,533	76,224	11,186	0	2,809,791	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/17/2024 2:15 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B				1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB				1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	ADMINISTRATION & GENERAL				5.01
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT MOB				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	682,640		30.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	281,618		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	1,639		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	304,124		54.00
56.00	05600	RADIOISOTOPE	0	20,465		56.00
60.00	06000	LABORATORY	0	179,819		60.00
60.02	06002	GERO PSYCH	0	28,739		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	2,175		62.00
65.00	06500	RESPIRATORY THERAPY	0	52,997		65.00
66.00	06600	PHYSICAL THERAPY	0	26,593		66.00
69.00	06900	ELECTROCARDIOLOGY	0	86,663		69.00
69.01	06901	PULMONARY REHAB	0	16,808		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,336		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,743		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	102,276		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	475,626		88.00
90.00	09000	CLINIC	0	8,713		90.00
91.00	09100	EMERGENCY	0	181,145		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	04040	OP NURSING	0	50,349		93.00
93.01	04950	DIABETIC EDUCATION	0	70,980		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,606,448		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,864		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	196,770		192.00
194.00	07950	NAUVOO APARTMENTS	0	0		194.00
194.01	07952	FITNESS CENTER	0	2,709		194.01
194.02	07951	BEAUTY SHOP	0	0		194.02
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,809,791		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/17/2024 2:15 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (WFMG/ADMIN SQUARE FEET)	NEW BLDG & FIXT (NEW B (NEW HOSP SQUARE FE)	BLDG & FIXT MOB (MOB SQUARE FEET)	NEW MVBLE EQUIP (HOSP/WFMG/ADM IN SQUARE FEET)	MOB MVBLE EQUIP (MOB SQUARE FEET)	
			1.00	1.02	1.03	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	8,322					1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	50,253				1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	0	0	25,000			1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				58,575		2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP				0	25,000	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	2,929	16,164	8,470	19,093	8,470	5.01
7.00	00700	OPERATION OF PLANT	364	2,151	0	2,515	0	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	511	0	511	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	182	0	182	0	8.00
9.00	00900	HOUSEKEEPING	0	548	201	548	201	9.00
10.00	01000	DIETARY	0	954	0	954	0	10.00
11.00	01100	CAFETERIA	0	491	0	491	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	265	0	265	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	897	787	0	1,684	0	16.00
17.00	01700	SOCIAL SERVICE	0	175	0	175	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	9,782	0	9,782	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,229	0	4,229	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,429	0	4,429	0	54.00
56.00	05600	RADIOISOTOPE	0	310	0	310	0	56.00
60.00	06000	LABORATORY	0	1,688	0	1,688	0	60.00
60.02	06002	GERO PSYCH	0	0	972	0	972	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	691	0	691	0	65.00
66.00	06600	PHYSICAL THERAPY	0	259	0	259	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,541	0	1,541	0	69.00
69.01	06901	PULMONARY REHAB	0	0	961	0	961	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	326	0	326	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	1,251	0	1,251	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,722	0	9,340	1,722	9,340	88.00
90.00	09000	CLINIC	0	0	506	0	506	90.00
91.00	09100	EMERGENCY	0	1,852	0	1,852	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OP NURSING	0	889	0	889	0	93.00
93.01	04950	DIABETIC EDUCATION	0	1,215	0	1,215	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,912	50,179	20,961	56,091	20,961	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	74	0	74	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,410	0	4,039	2,410	4,039	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	30,152	1,420,378	308,299	1,029,006	21,956	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.623168	28.264541	12.331960	17.567324	0.878240	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/17/2024 2:15 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (SALARIES)	Reconciliation	ADMINISTRATION & GENERAL (ACCUM. COST)	OPERATION OF PLANT (HOSP ONLY SQUARE FT)	OPERATION OF PLANT MOB (MOB SQUARE FEET)	
			4.00	5A.01	5.01	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	20,891,646					4.00
5.01	00550	ADMINISTRATION & GENERAL	3,548,558	-8,934,216	34,917,086			5.01
7.00	00700	OPERATION OF PLANT	306,106	0	1,116,712	31,938		7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	50,932	0	16,019	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	214,398	182	0	8.00
9.00	00900	HOUSEKEEPING	406,159	0	612,390	548	201	9.00
10.00	01000	DIETARY	194,568	0	370,067	954	0	10.00
11.00	01100	CAFETERIA	197,081	0	265,363	491	0	11.00
13.00	01300	NURSING ADMINISTRATION	117,312	0	169,816	265	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	371,375	0	536,159	787	0	16.00
17.00	01700	SOCIAL SERVICE	61,914	0	85,743	175	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,474,312	0	3,412,391	9,782	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	627,925	0	1,809,785	4,229	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	45,526	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	814,310	0	2,114,800	4,429	0	54.00
56.00	05600	RADIOISOTOPE	0	0	154,836	310	0	56.00
60.00	06000	LABORATORY	1,174,965	0	2,790,214	1,688	0	60.00
60.02	06002	GERO PSYCH	0	0	518,838	0	972	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	79,194	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	350,062	0	580,512	691	0	65.00
66.00	06600	PHYSICAL THERAPY	330,074	0	431,541	259	0	66.00
69.00	06900	ELECTROCARDIOLOGY	121,946	0	263,783	1,541	0	69.00
69.01	06901	PULMONARY REHAB	57,548	0	85,717	0	961	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	54,700	0	106,682	326	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	454,214	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	278,549	0	1,299,027	1,251	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,359,182	0	10,691,409	0	9,340	88.00
90.00	09000	CLINIC	16,939	0	43,779	0	506	90.00
91.00	09100	EMERGENCY	707,275	0	2,822,714	1,852	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OP NURSING	76,101	0	146,028	889	0	93.00
93.01	04950	DIABETIC EDUCATION	199,736	0	332,324	1,215	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,846,697	-8,934,216	31,604,894	31,864	11,980	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,392	74	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,993,036	0	3,205,413	0	4,039	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	51,913	0	103,387	0	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,334,517		8,934,216	1,402,444	63,964	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.255342		0.255869	43.911453	3.993008	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		914,783	135,555	8,085	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.026199	4.244317	0.504713	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: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/17/2024 2:15 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (NEW HOSP, WFMG/ADMIN, MOB SQFT)	DIETARY (HOSP PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	68,714					8.00
9.00	00900	HOUSEKEEPING	12,175	52,055				9.00
10.00	01000	DIETARY	348	954	2,377			10.00
11.00	01100	CAFETERIA	0	491	0	256,263		11.00
13.00	01300	NURSING ADMINISTRATION	0	265	0	4,521	85,291	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,684	0	17,461	0	16.00
17.00	01700	SOCIAL SERVICE	0	175	0	104	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,261	9,782	2,377	42,216	42,216	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,556	4,229	0	20,985	20,985	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,023	4,429	0	26,765	0	54.00
56.00	05600	RADIOISOTOPE	0	310	0	0	0	56.00
60.00	06000	LABORATORY	0	1,688	0	37,612	0	60.00
60.02	06002	GERO PSYCH	0	972	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	136	691	0	6,823	0	65.00
66.00	06600	PHYSICAL THERAPY	0	259	0	8,000	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,541	0	2,499	0	69.00
69.01	06901	PULMONARY REHAB	0	961	0	2,127	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	326	0	2,126	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	1,251	0	4,701	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,058	11,062	0	56,142	0	88.00
90.00	09000	CLINIC	0	506	0	0	0	90.00
91.00	09100	EMERGENCY	4,874	1,852	0	20,016	20,016	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OP NURSING	0	889	0	2,074	2,074	93.00
93.01	04950	DIABETIC EDUCATION	0	1,215	0	2,091	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,431	45,532	2,377	256,263	85,291	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	74	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,283	6,449	0	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.01	07952	FITNESS CENTER	0	0	0	0	0	194.01
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	277,248	843,072	523,503	362,774	235,596	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.034811	16.195793	220.236853	1.415632	2.762261	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,730	48,853	58,437	32,001	18,533	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.214367	0.938488	24.584350	0.124876	0.217291	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: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/17/2024 2:15 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B					1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB					1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	ADMINISTRATION & GENERAL					5.01
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT MOB					7.01
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	99,695,920				16.00
17.00	01700	SOCIAL SERVICE	0	100			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	6,755,825	98	0		30.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	9,266,921	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	583,471	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,048,637	0	0		54.00
56.00	05600	RADIOISOTOPE	774,512	0	0		56.00
60.00	06000	LABORATORY	20,795,297	0	0		60.00
60.02	06002	GERO PSYCH	1,179,022	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	131,049	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	2,164,551	0	0		65.00
66.00	06600	PHYSICAL THERAPY	1,404,870	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	1,080,977	0	0		69.00
69.01	06901	PULMONARY REHAB	279,302	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	843,070	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,101,381	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,014,068	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	17,422,784	0	0		88.00
90.00	09000	CLINIC	198,983	0	0		90.00
91.00	09100	EMERGENCY	6,008,485	2	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	OP NURSING	603,785	0	0		93.00
93.01	04950	DIABETIC EDUCATION	38,930	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,695,920	100	0		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0		194.00
194.01	07952	FITNESS CENTER	0	0	0		194.01
194.02	07951	BEAUTY SHOP	0	0	0		194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	759,895	118,348	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.007622	1,183.480000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	76,224	11,186	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000765	111.860000	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/17/2024 2:15 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	5,838,721		5,838,721	0	0	30.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,764,257		2,764,257	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	61,622		61,622	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,163,594		3,163,594	0	0	54.00
56.00	05600	RADIOISOTOPE	218,991		218,991	0	0	56.00
60.00	06000	LABORATORY	3,817,351		3,817,351	0	0	60.00
60.02	06002	GERO PSYCH	680,203		680,203	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	100,456		100,456	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	797,287	0	797,287	0	0	65.00
66.00	06600	PHYSICAL THERAPY	579,560	0	579,560	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	435,680		435,680	0	0	69.00
69.01	06901	PULMONARY REHAB	132,190		132,190	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	163,010		163,010	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	578,828		578,828	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,751,474		1,751,474	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,860,018		13,860,018	0	0	88.00
90.00	09000	CLINIC	66,713		66,713	0	0	90.00
91.00	09100	EMERGENCY	3,807,732		3,807,732	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,266,593		1,266,593		0	92.00
93.00	04040	OP NURSING	250,094		250,094	0	0	93.00
93.01	04950	DIABETIC EDUCATION	493,642		493,642	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	40,828,016	0	40,828,016	0	0	200.00
201.00		Less Observation Beds	1,266,593		1,266,593		0	201.00
202.00		Total (see instructions)	39,561,423	0	39,561,423	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/17/2024 2:15 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	4,159,780		4,159,780			30.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,351,788	7,915,133	9,266,921	0.298293	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	51,616	531,855	583,471	0.105613	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,161,830	22,886,807	24,048,637	0.131550	0.000000	54.00
56.00	05600	RADIOISOTOPE	38,636	735,876	774,512	0.282747	0.000000	56.00
60.00	06000	LABORATORY	1,465,383	19,329,914	20,795,297	0.183568	0.000000	60.00
60.02	06002	GERO PSYCH	0	1,179,022	1,179,022	0.576921	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	58,658	72,391	131,049	0.766553	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	899,903	1,264,648	2,164,551	0.368338	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,093,979	310,891	1,404,870	0.412536	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	47,482	1,033,495	1,080,977	0.403043	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	279,302	279,302	0.473287	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	566,362	276,708	843,070	0.193353	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	325,000	776,381	1,101,381	0.525547	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,458,957	3,555,111	5,014,068	0.349312	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	17,422,784	17,422,784			88.00
90.00	09000	CLINIC	0	198,983	198,983	0.335270	0.000000	90.00
91.00	09100	EMERGENCY	152,050	5,856,435	6,008,485	0.633726	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	16,329	2,579,716	2,596,045	0.487893	0.000000	92.00
93.00	04040	OP NURSING	962	602,823	603,785	0.414210	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	38,930	38,930	12.680247	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	12,848,715	86,847,205	99,695,920			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,848,715	86,847,205	99,695,920			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/17/2024 2:15 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
60.02	06002	GERO PSYCH	0.000000		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	PULMONARY REHAB	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040	OP NURSING	0.000000		93.00
93.01	04950	DIABETIC EDUCATION	0.000000		93.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		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: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/17/2024 2:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,838,721		5,838,721	0	5,838,721	30.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,764,257		2,764,257	0	2,764,257	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	61,622		61,622	0	61,622	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,163,594		3,163,594	0	3,163,594	54.00
56.00	05600	RADIOISOTOPE	218,991		218,991	0	218,991	56.00
60.00	06000	LABORATORY	3,817,351		3,817,351	0	3,817,351	60.00
60.02	06002	GERO PSYCH	680,203		680,203	0	680,203	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	100,456		100,456	0	100,456	62.00
65.00	06500	RESPIRATORY THERAPY	797,287	0	797,287	0	797,287	65.00
66.00	06600	PHYSICAL THERAPY	579,560	0	579,560	0	579,560	66.00
69.00	06900	ELECTROCARDIOLOGY	435,680		435,680	0	435,680	69.00
69.01	06901	PULMONARY REHAB	132,190		132,190	0	132,190	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	163,010		163,010	0	163,010	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	578,828		578,828	0	578,828	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,751,474		1,751,474	0	1,751,474	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,860,018		13,860,018	0	13,860,018	88.00
90.00	09000	CLINIC	66,713		66,713	0	66,713	90.00
91.00	09100	EMERGENCY	3,807,732		3,807,732	0	3,807,732	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,266,593		1,266,593		1,266,593	92.00
93.00	04040	OP NURSING	250,094		250,094	0	250,094	93.00
93.01	04950	DIABETIC EDUCATION	493,642		493,642	0	493,642	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	40,828,016	0	40,828,016	0	40,828,016	200.00
201.00		Less Observation Beds	1,266,593		1,266,593		1,266,593	201.00
202.00		Total (see instructions)	39,561,423	0	39,561,423	0	39,561,423	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/17/2024 2:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,159,780		4,159,780			30.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,351,788	7,915,133	9,266,921	0.298293	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	51,616	531,855	583,471	0.105613	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,161,830	22,886,807	24,048,637	0.131550	0.000000	54.00
56.00	05600	RADIOISOTOPE	38,636	735,876	774,512	0.282747	0.000000	56.00
60.00	06000	LABORATORY	1,465,383	19,329,914	20,795,297	0.183568	0.000000	60.00
60.02	06002	GERO PSYCH	0	1,179,022	1,179,022	0.576921	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	58,658	72,391	131,049	0.766553	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	899,903	1,264,648	2,164,551	0.368338	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,093,979	310,891	1,404,870	0.412536	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	47,482	1,033,495	1,080,977	0.403043	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	279,302	279,302	0.473287	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	566,362	276,708	843,070	0.193353	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	325,000	776,381	1,101,381	0.525547	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,458,957	3,555,111	5,014,068	0.349312	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	17,422,784	17,422,784	0.795511	0.000000	88.00
90.00	09000	CLINIC	0	198,983	198,983	0.335270	0.000000	90.00
91.00	09100	EMERGENCY	152,050	5,856,435	6,008,485	0.633726	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	16,329	2,579,716	2,596,045	0.487893	0.000000	92.00
93.00	04040	OP NURSING	962	602,823	603,785	0.414210	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	38,930	38,930	12.680247	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	12,848,715	86,847,205	99,695,920			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,848,715	86,847,205	99,695,920			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/17/2024 2:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.298293		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.105613		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131550		54.00
56.00	05600	RADIOISOTOPE	0.282747		56.00
60.00	06000	LABORATORY	0.183568		60.00
60.02	06002	GERO PSYCH	0.576921		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.766553		62.00
65.00	06500	RESPIRATORY THERAPY	0.368338		65.00
66.00	06600	PHYSICAL THERAPY	0.412536		66.00
69.00	06900	ELECTROCARDIOLOGY	0.403043		69.00
69.01	06901	PULMONARY REHAB	0.473287		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.193353		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.525547		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.349312		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.795511		88.00
90.00	09000	CLINIC	0.335270		90.00
91.00	09100	EMERGENCY	0.633726		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.487893		92.00
93.00	04040	OP NURSING	0.414210		93.00
93.01	04950	DIABETIC EDUCATION	12.680247		93.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		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

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/17/2024 2:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,764,257	281,618	2,482,639	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	61,622	1,639	59,983	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,163,594	304,124	2,859,470	0	0	54.00
56.00	05600	RADIOISOTOPE	218,991	20,465	198,526	0	0	56.00
60.00	06000	LABORATORY	3,817,351	179,819	3,637,532	0	0	60.00
60.02	06002	GERO PSYCH	680,203	28,739	651,464	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	100,456	2,175	98,281	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	797,287	52,997	744,290	0	0	65.00
66.00	06600	PHYSICAL THERAPY	579,560	26,593	552,967	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	435,680	86,663	349,017	0	0	69.00
69.01	06901	PULMONARY REHAB	132,190	16,808	115,382	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	163,010	20,336	142,674	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	578,828	12,743	566,085	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,751,474	102,276	1,649,198	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,860,018	475,626	13,384,392	0	0	88.00
90.00	09000	CLINIC	66,713	8,713	58,000	0	0	90.00
91.00	09100	EMERGENCY	3,807,732	181,145	3,626,587	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,266,593	148,085	1,118,508	0	0	92.00
93.00	04040	OP NURSING	250,094	50,349	199,745	0	0	93.00
93.01	04950	DIABETIC EDUCATION	493,642	70,980	422,662	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	34,989,295	2,071,893	32,917,402	0	0	200.00
201.00		Less Observation Beds	1,266,593	148,085	1,118,508	0	0	201.00
202.00		Total (line 200 minus line 201)	33,722,702	1,923,808	31,798,894	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part II | Date/Time Prepared: 5/17/2024 2:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,764,257	9,266,921	0.298293		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	61,622	583,471	0.105613		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,163,594	24,048,637	0.131550		54.00
56.00	05600	RADIOISOTOPE	218,991	774,512	0.282747		56.00
60.00	06000	LABORATORY	3,817,351	20,795,297	0.183568		60.00
60.02	06002	GERO PSYCH	680,203	1,179,022	0.576921		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	100,456	131,049	0.766553		62.00
65.00	06500	RESPIRATORY THERAPY	797,287	2,164,551	0.368338		65.00
66.00	06600	PHYSICAL THERAPY	579,560	1,404,870	0.412536		66.00
69.00	06900	ELECTROCARDIOLOGY	435,680	1,080,977	0.403043		69.00
69.01	06901	PULMONARY REHAB	132,190	279,302	0.473287		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	163,010	843,070	0.193353		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	578,828	1,101,381	0.525547		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,751,474	5,014,068	0.349312		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	13,860,018	17,422,784	0.795511		88.00
90.00	09000	CLINIC	66,713	198,983	0.335270		90.00
91.00	09100	EMERGENCY	3,807,732	6,008,485	0.633726		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,266,593	2,596,045	0.487893		92.00
93.00	04040	OP NURSING	250,094	603,785	0.414210		93.00
93.01	04950	DIABETIC EDUCATION	493,642	38,930	12.680247		93.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	34,989,295	95,536,140			200.00
201.00		Less Observation Beds	1,266,593	0			201.00
202.00		Total (line 200 minus line 201)	33,722,702	95,536,140			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/17/2024 2:15 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	281,618	9,266,921	0.030390	825,891	25,099	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,639	583,471	0.002809	30,505	86	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	304,124	24,048,637	0.012646	541,018	6,842	54.00
56.00	05600	RADIOISOTOPE	20,465	774,512	0.026423	27,433	725	56.00
60.00	06000	LABORATORY	179,819	20,795,297	0.008647	686,698	5,938	60.00
60.02	06002	GERO PSYCH	28,739	1,179,022	0.024375	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,175	131,049	0.016597	44,223	734	62.00
65.00	06500	RESPIRATORY THERAPY	52,997	2,164,551	0.024484	504,331	12,348	65.00
66.00	06600	PHYSICAL THERAPY	26,593	1,404,870	0.018929	372,073	7,043	66.00
69.00	06900	ELECTROCARDIOLOGY	86,663	1,080,977	0.080171	14,598	1,170	69.00
69.01	06901	PULMONARY REHAB	16,808	279,302	0.060179	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,336	843,070	0.024121	69,399	1,674	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,743	1,101,381	0.011570	321,418	3,719	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	102,276	5,014,068	0.020398	760,039	15,503	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	475,626	17,422,784	0.027299	0	0	88.00
90.00	09000	CLINIC	8,713	198,983	0.043788	0	0	90.00
91.00	09100	EMERGENCY	181,145	6,008,485	0.030148	48,047	1,449	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	148,085	2,596,045	0.057043	4,900	280	92.00
93.00	04040	OP NURSING	50,349	603,785	0.083389	588	49	93.00
93.01	04950	DIABETIC EDUCATION	70,980	38,930	1.823273	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,071,893	95,536,140		4,251,161	82,659	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/17/2024 2:15 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.02	06002	GERO PSYCH	0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04040	OP NURSING	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/17/2024 2:15 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	9,266,921	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	583,471	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,048,637	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	774,512	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	20,795,297	0.000000	60.00
60.02	06002	GERO PSYCH	0	0	0	1,179,022	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	131,049	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,164,551	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,404,870	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,080,977	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	0	0	279,302	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	843,070	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,101,381	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,014,068	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	17,422,784	0.000000	88.00
90.00	09000	CLINIC	0	0	0	198,983	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	6,008,485	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,596,045	0.000000	92.00
93.00	04040	OP NURSING	0	0	0	603,785	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	38,930	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	95,536,140		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/17/2024 2:15 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	825,891	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	30,505	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	541,018	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	27,433	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	686,698	0	0	0	60.00
60.02	06002	GERO PSYCH	0.000000	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	44,223	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	504,331	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	372,073	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	14,598	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0.000000	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	69,399	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	321,418	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	760,039	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	48,047	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	4,900	0	0	0	92.00
93.00	04040	OP NURSING	0.000000	588	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0.000000	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		4,251,161	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/17/2024 2:15 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
60.02	06002	GERO PSYCH	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	PULMONARY REHAB	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OP NURSING	0	0		93.00
93.01	04950	DIABETIC EDUCATION	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/17/2024 2:15 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	0.298293	0	2,386,301	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.105613	0	159,712	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131550	0	8,147,716	0	0	54.00
56.00	05600	RADIOISOTOPE	0.282747	0	369,465	0	0	56.00
60.00	06000	LABORATORY	0.183568	0	6,480,111	0	0	60.00
60.02	06002	GERO PSYCH	0.576921	0	1,040,901	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.766553	0	37,923	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.368338	0	427,736	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.412536	0	196,782	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.403043	0	275,217	0	0	69.00
69.01	06901	PULMONARY REHAB	0.473287	0	185,724	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.193353	0	88,131	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.525547	0	169,231	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.349312	0	1,350,083	1,379	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0.335270	0	127,980	0	0	90.00
91.00	09100	EMERGENCY	0.633726	0	1,786,615	774	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.487893	0	789,141	0	0	92.00
93.00	04040	OP NURSING	0.414210	0	310,575	0	0	93.00
93.01	04950	DIABETIC EDUCATION	12.680247	0	16,217	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	24,345,561	2,153	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	24,345,561	2,153	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/17/2024 2:15 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	711,817	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	16,868	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,071,832	0		54.00
56.00	05600	RADIOISOTOPE	104,465	0		56.00
60.00	06000	LABORATORY	1,189,541	0		60.00
60.02	06002	GERO PSYCH	600,518	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	29,070	0		62.00
65.00	06500	RESPIRATORY THERAPY	157,551	0		65.00
66.00	06600	PHYSICAL THERAPY	81,180	0		66.00
69.00	06900	ELECTROCARDIOLOGY	110,924	0		69.00
69.01	06901	PULMONARY REHAB	87,901	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,040	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88,939	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	471,600	482		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	42,908	0		90.00
91.00	09100	EMERGENCY	1,132,224	491		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	385,016	0		92.00
93.00	04040	OP NURSING	128,643	0		93.00
93.01	04950	DIABETIC EDUCATION	205,636	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	6,633,673	973		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,633,673	973		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Component CCN: 14-Z305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/17/2024 2:15 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.02	06002	GERO PSYCH	0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04040	OP NURSING	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Component CCN: 14-Z305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/17/2024 2:15 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	9,266,921	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	583,471	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,048,637	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	774,512	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	20,795,297	0.000000	60.00
60.02	06002	GERO PSYCH	0	0	0	1,179,022	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	131,049	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,164,551	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,404,870	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,080,977	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	0	0	279,302	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	843,070	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,101,381	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,014,068	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	17,422,784	0.000000	88.00
90.00	09000	CLINIC	0	0	0	198,983	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	6,008,485	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,596,045	0.000000	92.00
93.00	04040	OP NURSING	0	0	0	603,785	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	38,930	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	95,536,140		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Component CCN: 14-Z305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/17/2024 2:15 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	44,908	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	112,667	0	0	0	60.00
60.02	06002	GERO PSYCH	0.000000	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	1,788	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	132,081	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	538,643	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,820	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0.000000	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	14,206	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	165,270	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	2,466	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040	OP NURSING	0.000000	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0.000000	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,013,849	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Component CCN: 14-Z305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/17/2024 2:15 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
60.02	06002	GERO PSYCH	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	PULMONARY REHAB	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OP NURSING	0	0		93.00
93.01	04950	DIABETIC EDUCATION	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1305 | Component CCN: 14-Z305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/17/2024 2:15 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.298293	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.105613	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131550	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.282747	0	0	0	0	56.00
60.00	06000	LABORATORY	0.183568	0	0	0	0	60.00
60.02	06002	GERO PSYCH	0.576921	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.766553	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.368338	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.412536	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.403043	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0.473287	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.193353	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.525547	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.349312	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0.335270	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.633726	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.487893	0	0	0	0	92.00
93.00	04040	OP NURSING	0.414210	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	12.680247	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1305 | Component CCN: 14-Z305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 5/17/2024 2:15 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
60.02	06002	GERO PSYCH	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	PULMONARY REHAB	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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				88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OP NURSING	0	0		93.00
93.01	04950	DIABETIC EDUCATION	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part I | Date/Time Prepared: 5/17/2024 2:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	682,640	169,428	513,212	2,270	226.08	30.00
43.00	NURSERY	0		0	0	0.00	43.00
200.00	Total (lines 30 through 199)	682,640		513,212	2,270		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	89	20,121		30.00
43.00	NURSERY	0	0		43.00
200.00	Total (lines 30 through 199)	89	20,121		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/17/2024 2:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	281,618	9,266,921	0.030390	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,639	583,471	0.002809	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	304,124	24,048,637	0.012646	0	0	54.00
56.00	05600	RADIOISOTOPE	20,465	774,512	0.026423	0	0	56.00
60.00	06000	LABORATORY	179,819	20,795,297	0.008647	0	0	60.00
60.02	06002	GERO PSYCH	28,739	1,179,022	0.024375	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,175	131,049	0.016597	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	52,997	2,164,551	0.024484	0	0	65.00
66.00	06600	PHYSICAL THERAPY	26,593	1,404,870	0.018929	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	86,663	1,080,977	0.080171	0	0	69.00
69.01	06901	PULMONARY REHAB	16,808	279,302	0.060179	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,336	843,070	0.024121	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,743	1,101,381	0.011570	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	102,276	5,014,068	0.020398	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	475,626	17,422,784	0.027299	0	0	88.00
90.00	09000	CLINIC	8,713	198,983	0.043788	0	0	90.00
91.00	09100	EMERGENCY	181,145	6,008,485	0.030148	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	148,085	2,596,045	0.057043	0	0	92.00
93.00	04040	OP NURSING	50,349	603,785	0.083389	0	0	93.00
93.01	04950	DIABETIC EDUCATION	70,980	38,930	1.823273	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,071,893	95,536,140		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part III Date/Time Prepared: 5/17/2024 2:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,270	0.00	89	30.00
43.00	04300	NURSERY		0	0	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	2,270		89	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost		
			9.00	13.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
43.00	04300	NURSERY	0	0		43.00
200.00		Total (lines 30 through 199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/17/2024 2:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.02	06002	GERO PSYCH	0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04040	OP NURSING	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/17/2024 2:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	9,266,921	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	583,471	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,048,637	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	774,512	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	20,795,297	0.000000	60.00
60.02	06002	GERO PSYCH	0	0	0	1,179,022	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	131,049	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,164,551	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,404,870	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,080,977	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	0	0	279,302	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	843,070	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,101,381	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,014,068	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	17,422,784	0.000000	88.00
90.00	09000	CLINIC	0	0	0	198,983	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	6,008,485	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,596,045	0.000000	92.00
93.00	04040	OP NURSING	0	0	0	603,785	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	38,930	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	95,536,140		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/17/2024 2:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
60.02	06002	GERO PSYCH	0.000000	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0.000000	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040	OP NURSING	0.000000	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0.000000	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/17/2024 2:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
60.02	06002	GERO PSYCH	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	PULMONARY REHAB	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OP NURSING	0	0		93.00
93.01	04950	DIABETIC EDUCATION	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50 through 199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/17/2024 2:15 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)	3,032	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,270	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)	1,615	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	748	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	14	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,062	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)	704	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	193.31	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	193.31	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,838,721	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	2,706	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,449,144	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,389,577	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,389,577	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)	1,933.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,053,632	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)	2,053,632	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/17/2024 2:15 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)	0	0	0.00	0	0	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)	1,314,519	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)	3,368,151	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)	1,361,353	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	1,361,353	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)	655	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,933.73	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,266,593	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/17/2024 2:15 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	682,640	5,838,721	0.116916	1,266,593	148,085	90.00
91.00	Nursing Program cost	0	5,838,721	0.000000	1,266,593	0	91.00
92.00	Allied health cost	0	5,838,721	0.000000	1,266,593	0	92.00
93.00	All other Medical Education	0	5,838,721	0.000000	1,266,593	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/17/2024 2:15 pm

Title XIX | Hospital | PPS

	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS			
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,032	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,270	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.	do	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,615	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		748	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		14	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		89	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		193.31	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		193.31	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,838,721	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)	5	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)	x	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)	x	2,706	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)	x	0	25.00
26.00	Total swing-bed cost (see instructions)		1,449,144	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,389,577	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 minus line 36)	27	4,389,577	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)		1,933.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		172,102	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)		172,102	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/17/2024 2:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	172,102	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)	20,121	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)	20,121	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	151,981	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)	655	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,933.73	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,266,593	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/17/2024 2:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	682,640	5,838,721	0.116916	1,266,593	148,085	90.00
91.00	Nursing Program cost	0	5,838,721	0.000000	1,266,593	0	91.00
92.00	Allied health cost	0	5,838,721	0.000000	1,266,593	0	92.00
93.00	All other Medical Education	0	5,838,721	0.000000	1,266,593	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/17/2024 2:15 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		2,138,281		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.298293	825,891	246,358	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.105613	30,505	3,222	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131550	541,018	71,171	54.00
56.00	05600	RADIOISOTOPE	0.282747	27,433	7,757	56.00
60.00	06000	LABORATORY	0.183568	686,698	126,056	60.00
60.02	06002	GERO PSYCH	0.576921	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.766553	44,223	33,899	62.00
65.00	06500	RESPIRATORY THERAPY	0.368338	504,331	185,764	65.00
66.00	06600	PHYSICAL THERAPY	0.412536	372,073	153,494	66.00
69.00	06900	ELECTROCARDIOLOGY	0.403043	14,598	5,884	69.00
69.01	06901	PULMONARY REHAB	0.473287	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.193353	69,399	13,419	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.525547	321,418	168,920	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.349312	760,039	265,491	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.335270	0	0	90.00
91.00	09100	EMERGENCY	0.633726	48,047	30,449	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.487893	4,900	2,391	92.00
93.00	04040	OP NURSING	0.414210	588	244	93.00
93.01	04950	DIABETIC EDUCATION	12.680247	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,251,161	1,314,519	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,251,161		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3

Component CCN: 14-Z305 | Date/Time Prepared: 5/17/2024 2:15 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.298293	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.105613	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131550	44,908	5,908	54.00
56.00	05600	RADIOISOTOPE	0.282747	0	0	56.00
60.00	06000	LABORATORY	0.183568	112,667	20,682	60.00
60.02	06002	GERO PSYCH	0.576921	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.766553	1,788	1,371	62.00
65.00	06500	RESPIRATORY THERAPY	0.368338	132,081	48,650	65.00
66.00	06600	PHYSICAL THERAPY	0.412536	538,643	222,210	66.00
69.00	06900	ELECTROCARDIOLOGY	0.403043	1,820	734	69.00
69.01	06901	PULMONARY REHAB	0.473287	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.193353	14,206	2,747	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.525547	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.349312	165,270	57,731	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.335270	0	0	90.00
91.00	09100	EMERGENCY	0.633726	2,466	1,563	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.487893	0	0	92.00
93.00	04040	OP NURSING	0.414210	0	0	93.00
93.01	04950	DIABETIC EDUCATION	12.680247	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,013,849	361,596	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)		1,013,849		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1305	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/17/2024 2:15 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,634,646	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 including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,634,646	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	6,700,992	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)	50,147	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,570,128	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,080,717	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	3,080,717	30.00
31.00	Primary payer payments	539	31.00
32.00	Subtotal (line 30 minus line 31)	3,080,178	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)	328,179	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	213,316	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	309,774	36.00
37.00	Subtotal (see instructions)	3,293,494	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,293,494	40.00
40.01	Sequestration adjustment (see instructions)	65,870	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,617,766	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)	-390,142	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: 14-1305	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/17/2024 2:15 pm
	Title XVIII	Hospital	Cost

		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00
		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: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/17/2024 2:15 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		2,797,099		3,609,558	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/02/2023	264,902	08/02/2023	8,211	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	11/29/2023	243,391	11/29/2023	3	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)		21,511		8,208	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)		2,818,610		3,617,766	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		161,892		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		390,142	6.02
7.00	Total Medicare program liability (see instructions)		2,980,502		3,227,624	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: 14-1305 | Component CCN: 14-Z305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/17/2024 2:15 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		1,800,594		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/02/2023	73,907		0	3.01
3.02		11/29/2023	258,403		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		332,310		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)		2,132,904		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		439,485		0	6.02
7.00	Total Medicare program liability (see instructions)		1,693,419		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: 14-1305	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/17/2024 2:15 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
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment		108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1305 | Component CCN: 14-Z305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/17/2024 2:15 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)	1,374,967	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)	365,212	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	704	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,740,179	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,740,179	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,740,179	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	12,200	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,727,979	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,727,979	0	19.00
19.01	Sequestration adjustment (see instructions)	34,560	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	2,132,904	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)	-439,485	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1305	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/17/2024 2:15 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,368,151	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)	3,368,151	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,401,833	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)	3,401,833	19.00
20.00	Deductibles (exclude professional component)	380,800	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,021,033	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,021,033	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	31,224	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	20,296	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	27,669	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,041,329	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)	3,041,329	30.00
30.01	Sequestration adjustment (see instructions)	60,827	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,818,610	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)	161,892	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/17/2024 2:15 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	14,532,711	0	0	0	1.00
2.00	Temporary investments	41,311	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	18,822,937	0	0	0	4.00
5.00	Other receivable	2,690,706	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,626,396	0	0	0	6.00
7.00	Inventory	510,994	0	0	0	7.00
8.00	Prepaid expenses	707,430	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)	25,679,693	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	514,957	0	0	0	12.00
13.00	Land improvements	1,412,947	0	0	0	13.00
14.00	Accumulated depreciation	-912,819	0	0	0	14.00
15.00	Buildings	30,011,843	0	0	0	15.00
16.00	Accumulated depreciation	-17,715,081	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	10,926,076	0	0	0	23.00
24.00	Accumulated depreciation	-7,250,395	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	1,968,769	0	0	0	27.00
28.00	Accumulated depreciation	-1,968,769	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)	16,987,528	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	7,101,379	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,028,346	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,129,725	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	50,796,946	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,138,194	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,153,439	0	0	0	38.00
39.00	Payroll taxes payable	206,027	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,204,003	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	78,667	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,780,330	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	15,519,734	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	104,148	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15,623,882	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	22,404,212	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	28,392,734				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)	28,392,734	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	50,796,946	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/17/2024 2:15 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		25,666,137		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,620,277				2.00
3.00	Total (sum of line 1 and line 2)		28,286,414		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	CHG IN INT IN FOUNDATION	60,288		0		0	5.00
6.00	RESTRICTED CONTRIBUTIONS	46,032		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)		106,320		0		10.00
11.00	Subtotal (line 3 plus line 10)		28,392,734		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)		28,392,734		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	CHG IN INT IN FOUNDATION		0			5.00
6.00	RESTRICTED CONTRIBUTIONS		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: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/17/2024 2:15 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,192,763		5,192,763	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)	5,192,763		5,192,763	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)	5,192,763		5,192,763	17.00
18.00	Ancillary services	8,194,254	65,394,622	73,588,876	18.00
19.00	Outpatient services	169,436	15,472,201	15,641,637	19.00
20.00	RURAL HEALTH CLINIC	0	17,529,193	17,529,193	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN OFFICE	0	2,218,575	2,218,575	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	13,556,453	100,614,591	114,171,044	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		47,612,786		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)		47,612,786		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1305 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/17/2024 2:15 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	114,171,044	1.00
2.00	Less contractual allowances and discounts on patients' accounts	67,347,306	2.00
3.00	Net patient revenues (line 1 minus line 2)	46,823,738	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	47,612,786	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-789,048	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	6,926	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	32,590	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	111,926	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	6,339	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	63,107	22.00
23.00	Governmental appropriations	0	23.00
24.00	HOSPITAL OTHER INCOME	539,769	24.00
24.01	EQUITY EARNINGS ON INVESTMENTS	0	24.01
24.02	CONTRIBUTIONS & GRANTS LONG LIVED	232,823	24.02
24.03	RELEASED FROM RESTRICTION	0	24.03
24.04	340B PHARMACY REVENUE	622,318	24.04
24.05	SALARY REIMBURSEMENTS	20,108	24.05
24.06	GAIN ON DISPOSAL OF PROPERTY & EQUIP	0	24.06
24.07	EQUITY IN EARNINGS OF UNCONSOLIDATED	741,417	24.07
24.50	COVID-19 PHE Funding	1,629,313	24.50
25.00	Total other income (sum of lines 6-24)	4,006,636	25.00
26.00	Total (line 5 plus line 25)	3,217,588	26.00
27.00	LOSS ON DISPOSAL	34,978	27.00
27.01	EQUITY IN EARNINGS OF UNCONSOLIDATED	0	27.01
27.02	TRANSFER BETWEEN AFFILIATES	562,333	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	597,311	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,620,277	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1305 | Component CCN: 14-3456 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/17/2024 2:15 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	3,008,068	0	3,008,068	-950,186	2,057,882	1.00
2.00	Physician Assistant	341,484	0	341,484	0	341,484	2.00
3.00	Nurse Practitioner	1,661,868	0	1,661,868	-3,509	1,658,359	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	192,810	0	192,810	0	192,810	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	2,194,484	0	2,194,484	2,138	2,196,622	9.00
10.00	Subtotal (sum of lines 1 through 9)	7,398,714	0	7,398,714	-951,557	6,447,157	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	144,719	144,719	0	144,719	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	144,719	144,719	0	144,719	14.00
15.00	Medical Supplies	0	736,916	736,916	0	736,916	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	184,349	184,349	-3,469	180,880	18.00
19.00	Other Health Care Costs	0	222,003	222,003	0	222,003	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,143,268	1,143,268	-3,469	1,139,799	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	7,398,714	1,287,987	8,686,701	-955,026	7,731,675	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	9,707	9,707	25.01
25.02	Chronic Care Management	145,373	0	145,373	0	145,373	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)	145,373	0	145,373	9,707	155,080	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	88,041	88,041	-323	87,718	29.00
30.00	Administrative Costs	725,081	0	725,081	31,864	756,945	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	725,081	88,041	813,122	31,541	844,663	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	8,269,168	1,376,028	9,645,196	-913,778	8,731,418	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1305 | Component CCN: 14-3456 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/17/2024 2:15 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	2,057,882		1.00
2.00	Physician Assistant	0	341,484		2.00
3.00	Nurse Practitioner	0	1,658,359		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	192,810		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	-18,526	2,178,096		9.00
10.00	Subtotal (sum of lines 1 through 9)	-18,526	6,428,631		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	144,719		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	144,719		14.00
15.00	Medical Supplies	0	736,916		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	180,880		18.00
19.00	Other Health Care Costs	-23,949	198,054		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	-23,949	1,115,850		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-42,475	7,689,200		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	9,707		25.01
25.02	Chronic Care Management	0	145,373		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	155,080		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-36,514	51,204		29.00
30.00	Administrative Costs	0	756,945		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-36,514	808,149		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-78,989	8,652,429		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1305 | Component CCN: 14-3456 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/17/2024 2:15 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC I Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	4.28	15,014	4,200	17,976		1.00
2.00	Physician Assistant	1.75	5,538	2,100	3,675		2.00
3.00	Nurse Practitioner	6.72	22,016	2,100	14,112		3.00
4.00	Subtotal (sum of lines 1 through 3)	12.75	42,568		35,763	42,568	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	2.17	1,613			1,613	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
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	14.92	44,181			44,181	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)	7,689,200	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	155,080	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	7,844,280	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.980230	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	808,149	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	5,207,589	15.00
16.00	Total overhead (sum of lines 14 and 15)	6,015,738	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	6,015,738	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	5,896,807	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	13,586,007	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1305 Component CCN: 14-3456	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/17/2024 2:15 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)		13,586,007	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		298,022	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		13,287,985	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		44,181	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)		44,181	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		300.76	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	325.23	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	300.76	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	8,452	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	2,542,024	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	5	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	1,504	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	1,504	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	2,543,528	16.00
16.01	Total program charges (see instructions)(from contractor's records)		2,902,065	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		403,658	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		353,787	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,634,065	16.04
16.05	Total program cost (see instructions)	0	1,987,852	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		147,160	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		467,075	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		1,987,852	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		101,696	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		2,089,548	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)		2,089,548	26.00
26.01	Sequestration adjustment (see instructions)		41,791	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		1,886,517	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)		161,240	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: 14-1305 | Component CCN: 14-3456 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/17/2024 2:15 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)	6,428,631	6,428,631	6,428,631	6,428,631	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000429	0.000813	0.000014	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	2,758	5,226	90	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	116,130	43,354	1,112	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	118,888	48,580	1,202	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	7,689,200	7,689,200	7,689,200	7,689,200	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	5,896,807	5,896,807	5,896,807	5,896,807	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.015462	0.006318	0.000156	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	91,176	37,256	920	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	210,064	85,836	2,122	0	10.00
11.00	Total number of injections/infusions (from your records)	552	1,045	18	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	380.55	82.14	117.89	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	186	362	10	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)	70,782	29,735	1,179	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)		298,022	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)		101,696	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-1305 | Component CCN: 14-3456 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-5 | Date/Time Prepared: 5/17/2024 2:15 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		1,915,539	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		08/02/2023	29,022	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)		-29,022	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,886,517	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		161,240	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		2,047,757	7.00

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