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: 14-1341	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/22/2024 9:54 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/22/2024 Time: 9:54 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PANA COMMUNITY HOSPITAL (14-1341) 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	James Moon		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	James Moon			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-235,739	-522,397	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	-298,261	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		92,892		0	10.00
10.01	RURAL HEALTH CLINIC II	0		248,791		0	10.01
10.02	RURAL HEALTH CLINIC III	0		7,803		0	10.02
200.00	TOTAL	0	-534,000	-172,911	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: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2024 9:54 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 101 E. 9TH STREET	PO Box:			1.00
2.00	City: PANA	State: IL	Zip Code: 62557-1716	County: CHRISTIAN	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	PANA COMMUNITY HOSPITAL	141341	99914	1	11/01/2004	N	O	N	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	PANA COMMUNITY HOSPITAL	14Z341	99914		04/06/2004	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	QUAD COUNTY HOME HEALTH AGENCY	147299	99914		01/01/1985	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	PANA COMMUNITY HOSPITAL HOSPICE	141575	99914		08/31/1994				14.00
15.00	Hospital-Based Health Clinic - RHC	COMMUNITY MEDICAL CLINIC PANA	148508	99914		03/18/2010	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	PANA MEDICAL GROUP	148633	99914		09/15/2022	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	COWDEN MEDICAL GROUP	148637	99914		08/01/2022	N	O	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	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			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/22/2024 9:54 am

		1.00	2.00	3.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/22/2024 9:54 am

		V	XVIII	XIX	
		1.00	2.00	3.00	
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1341	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/22/2024 9:54 am

		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

		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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/22/2024 9:54 am

		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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1341	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/22/2024 9:54 am

		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
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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.	Y		108.00

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

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				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.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	65,698	48,997	0	118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.		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

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		1.00	2.00	
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)	N		140.00

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

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

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

		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)	N	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

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		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: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/22/2024 9:54 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	02/28/2024	Y	02/28/2024	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

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	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.	Y	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?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			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.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4300	KEVIN.WELLEN@CLACONNECT.COM	43.00

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		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SIGNING DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/22/2024 9:54 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	8,030	15,000.00	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)		22	8,030	15,000.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		22	8,030	15,000.00	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	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		22				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

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	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	336	6	616			1.00
2.00	HMO and other (see instructions)	0	23				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	907	0	1,001			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	22			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,243	6	1,639			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,243	6	1,639	0.00	150.82	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	4,086	0	8,343	0.00	19.74	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	5.54	24.00
24.10	HOSPICE (non-distinct part)			9			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	2,759	0	16,051	0.00	23.41	26.00
26.01	RURAL HEALTH CLINIC II	1,836	0	6,957	0.00	15.28	26.01
26.02	RURAL HEALTH CLINIC III	416	0	3,459	0.00	5.81	26.02
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	220.60	27.00
28.00	Observation Bed Days		0	100			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			2			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: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/22/2024 9:54 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	128	3	209	1.00
2.00	HMO and other (see instructions)			0	6		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	128	3	209	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.25	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

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-1341 | Component CCN: 14-7299 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-4 | Date/Time Prepared: 5/22/2024 9:54 am

Home Health Agency I | PPS

		1.00	
0.00	County	CHRISTIAN	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	182	27	111	320	640	1.00
2.00	Unduplicated Census Count (see instructions)	241.00	36.00	150.00	427.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	6.20	0.00	6.20	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		0.00	0.00	0.00	5.00
6.00	Direct Nursing Service		8.65	0.00	8.65	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		4.25	0.38	4.63	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.23	0.03	0.26	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.12	0.01	0.13	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.14	0.00	0.14	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.15	0.00	0.15	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00

		CBSA Data	
		1.00	
	HOME HEALTH AGENCY CBSA CODES		
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.	2	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	99914	20.00
20.01		41180	20.01

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,330	206	22	8	1,566	21.00
22.00	Skilled Nursing Visit Charges	345,285	53,560	5,708	2,080	406,633	22.00
23.00	Physical Therapy Visits	1,695	299	33	5	2,032	23.00
24.00	Physical Therapy Visit Charges	442,983	78,338	8,633	1,310	531,264	24.00
25.00	Occupational Therapy Visits	279	118	4	0	401	25.00
26.00	Occupational Therapy Visit Charges	78,120	33,040	1,120	0	112,280	26.00
27.00	Speech Pathology Visits	35	8	1	0	44	27.00
28.00	Speech Pathology Visit Charges	9,800	2,240	280	0	12,320	28.00
29.00	Medical Social Service Visits	11	5	0	0	16	29.00
30.00	Medical Social Service Visit Charges	3,559	1,625	0	0	5,184	30.00
31.00	Home Health Aide Visits	13	14	0	0	27	31.00
32.00	Home Health Aide Visit Charges	2,033	2,198	0	0	4,231	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,363	650	60	13	4,086	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	881,780	171,001	15,741	3,390	1,071,912	35.00
36.00	Total Number of Episodes (standard/non outlier)	381		35	0	416	36.00
37.00	Total Number of Outlier Episodes		30		0	30	37.00
38.00	Total Non-Routine Medical Supply Charges	7,397	1,165	36	95	8,693	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1341 | Component CCN: 14-8508 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/22/2024 9:54 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			101 E. 9TH STREET, SUITE 105		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	PANA		IL	62557	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:30	20:00	08:30	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			Y	3	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			COMMUNITY MEDICAL CLINIC PANA		148508	14.00
14.01				COMMUNITY MEDICAL CLINIC OF ASSUMPTI		148575	14.01
14.02				COMMUNITY MEDICAL CLINIC OF NOKOMIS		148574	14.02

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1341
Component CCN: 14-8508

Period:
From 01/01/2023
To 12/31/2023

Worksheet S-8
Date/Time Prepared:
5/22/2024 9:54 am

RHC I | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		CHRISTIAN				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	20:00	08:30	20:00	08:30	20:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:30	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1341 | Component CCN: 14-8633 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/22/2024 9:54 am

RHC II | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			217 S LOCUST ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	PANA		IL	62557	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:30	20:00	08:30	11.00

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1341
Component CCN: 14-8633

Period:
From 01/01/2023
To 12/31/2023

Worksheet S-8
Date/Time Prepared:
5/22/2024 9:54 am

RHC II | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		CHRISTIAN				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	20:00	08:30	20:00	08:30	20:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:30	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1341 | Component CCN: 14-8637 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/22/2024 9:54 am

RHC III | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			209 E ELM ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	COWDEN		IL	62422	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:30	20:00	08:30	11.00

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1341
Component CCN: 14-8637

Period:
From 01/01/2023
To 12/31/2023

Worksheet S-8

Date/Time Prepared:
5/22/2024 9:54 am

RHC III | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		SHELBY				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	20:00	08:30	20:00	08:30	20:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:30	17:00				11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 14-1341
Hospice CCN: 14-1575

Period:
From 01/01/2023
To 12/31/2023

Worksheet S-9
PARTS I THROUGH IV
Date/Time Prepared:
5/22/2024 9:54 am

Hospice I

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	4,440	102	151	4,693	11.00
12.00	Hospice Inpatient Respite Care	9	0	0	9	12.00
13.00	Hospice General Inpatient Care	0	0	0	0	13.00
14.00	Total Hospice Days	4,449	102	151	4,702	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1341	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/22/2024 9:54 am

		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)	0.407019	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,240,934	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	2,859,933	5.00
6.00	Medicaid charges	15,944,540	6.00
7.00	Medicaid cost (line 1 times line 6)	6,489,731	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	388,864	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	22,435	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	388,864	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)	5,498	12,379	17,877	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,238	12,379	14,617	21.00
22.00	Payments received from patients for amounts previously written off as charity care	2,749	6,189	8,938	22.00
23.00	Cost of charity care (see instructions)	0	6,190	6,190	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)	1,785,281	26.00
27.00	Medicare reimbursable bad debts (see instructions)	308,847	27.00
27.01	Medicare allowable bad debts (see instructions)	475,149	27.01
28.00	Non-Medicare bad debt amount (see instructions)	1,310,132	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	699,551	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	705,741	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,094,605	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1341	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/22/2024 9:54 am

		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: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/22/2024 9:54 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,862,034	1,862,034	-775,025	1,087,009	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX		246,781	246,781	863,185	1,109,966	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		755,340	755,340	15,660	771,000	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,071,352	5,071,352	10,836	5,082,188	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	153,540	153,540	5.01
5.02	00550	DATA PROCESSING	396,055	302,050	698,105	-102,060	596,045	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	609,159	295,923	905,082	-51,480	853,602	5.03
5.04	00590	OTHER ADMIN AND GENERAL	1,037,444	1,932,475	2,969,919	-6,148	2,963,771	5.04
7.00	00700	OPERATION OF PLANT	272,946	887,017	1,159,963	0	1,159,963	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	60,439	60,439	8.00
9.00	00900	HOUSEKEEPING	371,321	111,327	482,648	-60,439	422,209	9.00
10.00	01000	DIETARY	326,295	307,550	633,845	-549,355	84,490	10.00
11.00	01100	CAFETERIA	0	0	0	307,409	307,409	11.00
13.00	01300	NURSING ADMINISTRATION	456,574	21,328	477,902	0	477,902	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	45,912	483,429	529,341	-474,553	54,788	14.00
15.00	01500	PHARMACY	260,110	1,085,027	1,345,137	-990,839	354,298	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	168,929	46,261	215,190	0	215,190	16.00
17.00	01700	SOCIAL SERVICE	122,793	13,945	136,738	0	136,738	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	289,356	56,558	345,914	22,136	368,050	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,013,948	577,325	1,591,273	0	1,591,273	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	726,751	1,167,116	1,893,867	0	1,893,867	50.00
53.00	05300	ANESTHESIOLOGY	0	35,850	35,850	0	35,850	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	680,414	762,381	1,442,795	0	1,442,795	54.00
60.00	06000	LABORATORY	758,817	575,470	1,334,287	0	1,334,287	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	591,222	171,525	762,747	0	762,747	65.00
66.00	06600	PHYSICAL THERAPY	763,478	79,041	842,519	0	842,519	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	50,855	50,855	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	423,698	423,698	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	990,839	990,839	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,121,780	674,299	2,796,079	-209	2,795,870	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,022,274	499,860	1,522,134	0	1,522,134	88.01
88.02	08802	RURAL HEALTH CLINIC III	362,077	54,151	416,228	0	416,228	88.02
91.00	09100	EMERGENCY	1,241,078	2,179,175	3,420,253	0	3,420,253	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,058,917	320,042	1,378,959	0	1,378,959	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	345,817	190,442	536,259	0	536,259	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,043,467	20,765,074	35,808,541	-111,511	35,697,030	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	257,874	51,649	309,523	0	309,523	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	144,483	144,483	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	144,857	19,978	164,835	-32,972	131,863	194.01
194.02	07952	FOUNDATION	59,030	2,537	61,567	0	61,567	194.02
194.03	07953	MOWEAQUA THERAPY	139,297	24,511	163,808	0	163,808	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	15,644,525	20,863,749	36,508,274	0	36,508,274	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/22/2024 9:54 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	1,087,009		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX	-246,781	863,185		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-11,696	759,304		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-624,753	4,457,435		4.00
5.01	00540	NONPATIENT TELEPHONES	-8,182	145,358		5.01
5.02	00550	DATA PROCESSING	0	596,045		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	853,602		5.03
5.04	00590	OTHER ADMIN AND GENERAL	-797,906	2,165,865		5.04
7.00	00700	OPERATION OF PLANT	-4,629	1,155,334		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	60,439		8.00
9.00	00900	HOUSEKEEPING	0	422,209		9.00
10.00	01000	DIETARY	0	84,490		10.00
11.00	01100	CAFETERIA	-73,838	233,571		11.00
13.00	01300	NURSING ADMINISTRATION	0	477,902		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	54,788		14.00
15.00	01500	PHARMACY	-31,419	322,879		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,981	207,209		16.00
17.00	01700	SOCIAL SERVICE	0	136,738		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	368,050		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-466,873	1,124,400		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-757,189	1,136,678		50.00
53.00	05300	ANESTHESIOLOGY	0	35,850		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,442,795		54.00
60.00	06000	LABORATORY	-6,686	1,327,601		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	-56,670	706,077		65.00
66.00	06600	PHYSICAL THERAPY	-3,500	839,019		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	50,855		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	423,698		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	990,839		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-25,695	2,770,175		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,522,134		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	416,228		88.02
91.00	09100	EMERGENCY	-1,071,331	2,348,922		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	1,378,959		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	1,878	538,137		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,193,251	31,503,779		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	309,523		192.00
194.00	07950	HOMEBOUND MEALS	0	144,483		194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	131,863		194.01
194.02	07952	FOUNDATION	0	61,567		194.02
194.03	07953	MOWEAQUA THERAPY	0	163,808		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,193,251	32,315,023		200.00

RECLASSIFICATIONS | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/22/2024 9:54 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DIETARY COSTS					
1.00	CAFETERIA	11.00	158,250	149,159		1.00
2.00	OTHER ADMIN AND GENERAL	5.04	50,173	47,290		2.00
3.00	HOMEBOUND MEALS	194.00	74,378	70,105		3.00
	0		282,801	266,554		
	B - CRNAS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	22,136		1.00
	0		0	22,136		
	C - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	101,345		1.00
	0		0	101,345		
	D - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	60,439		1.00
	0		0	60,439		
	E - TELEPHONE EXPENSES					
1.00	NONPATIENT TELEPHONES	5.01	51,480	102,060		1.00
2.00		0.00	0	0		2.00
	0		51,480	102,060		
	F - EMPLOYEE BENEFIT PORTION OF WELLNESS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	28,976	3,996		1.00
	TOTALS		28,976	3,996		
	G - RHC PHYSICIAN RECRUITMENT					
1.00	RURAL HEALTH CLINIC	88.00	0	2,266		1.00
	0		0	2,266		
	I - DEPRECIATION BLDG EXPANSION					
1.00	CAP REL COSTS-BLDG & FIXT NEW BDG EX	1.01	0	826,382		1.00
	0		0	826,382		
	J - DRUG COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	990,839		1.00
	0		0	990,839		
	K - MEDICAL SUPPLY & IMPLANTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	50,855		1.00
2.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	423,698		2.00
	0		0	474,553		
	M - BUILDING LEASE COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,475		1.00
	TOTALS		0	2,475		
500.00	Grand Total: Increases		363,257	2,853,045		500.00

RECLASSIFICATIONS | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/22/2024 9:54 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DIETARY COSTS						
1.00	DIETARY	10.00	282,801	266,554	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		282,801	266,554			
	B - CRNAS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	22,136	0		1.00
	0		0	22,136			
	C - PROPERTY INSURANCE						
1.00	OTHER ADMIN AND GENERAL	5.04	0	101,345	0		1.00
	0		0	101,345			
	D - LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	60,439	0		1.00
	0		0	60,439			
	E - TELEPHONE EXPENSES						
1.00	DATA PROCESSING	5.02		102,060	0		1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03	51,480		0		2.00
	0		51,480	102,060			
	F - EMPLOYEE BENEFIT PORTION OF WELLNESS						
1.00	FITNESS WELLNESS PROGRAM	194.01	28,976	3,996	0		1.00
	TOTALS		28,976	3,996			
	G - RHC PHYSICIAN RECRUITMENT						
1.00	OTHER ADMIN AND GENERAL	5.04	0	2,266	0		1.00
	0		0	2,266			
	I - DEPRECIATION BLDG EXPANSION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	826,382	9		1.00
	0		0	826,382			
	J - DRUG COSTS						
1.00	PHARMACY	15.00	0	990,839	0		1.00
	0		0	990,839			
	K - MEDICAL SUPPLY & IMPLANTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	474,553	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	474,553			
	M - BUILDING LEASE COSTS						
1.00	RURAL HEALTH CLINIC	88.00	0	2,475	10		1.00
	TOTALS		0	2,475			
500.00	Grand Total: Decreases		363,257	2,853,045			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/22/2024 9:54 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	51,361	80,360	0	80,360	0	1.00
2.00	Land Improvements	3,017,777	34,702	0	34,702	205,969	2.00
3.00	Buildings and Fixtures	31,503,247	1,667,719	0	1,667,719	341,209	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	929,759	1,479,275	0	1,479,275	312,727	5.00
6.00	Movable Equipment	7,781,003	563,953	0	563,953	1,417,452	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	43,283,147	3,826,009	0	3,826,009	2,277,357	8.00
9.00	Reconciling Items	-2,127,879	2,070,633	0	2,070,633	0	9.00
10.00	Total (line 8 minus line 9)	45,411,026	1,755,376	0	1,755,376	2,277,357	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	131,721	0	1.00
2.00	Land Improvements	2,846,510	0	2.00
3.00	Buildings and Fixtures	32,829,757	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	2,096,307	0	5.00
6.00	Movable Equipment	6,927,504	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	44,831,799	0	8.00
9.00	Reconciling Items	-57,246	0	9.00
10.00	Total (line 8 minus line 9)	44,889,045	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/22/2024 9:54 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,862,034	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT NEW BDG EX	0	0	246,781	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	690,844	52,844	11,652	0	0	2.00
3.00	Total (sum of lines 1-2)	2,552,878	52,844	258,433	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,862,034	1.00
1.01	CAP REL COSTS-BLDG & FIXT NEW BDG EX	0	246,781	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	755,340	2.00
3.00	Total (sum of lines 1-2)	0	2,864,155	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 5/22/2024 9:54 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	21,623,886	0	21,623,886	0.482334	48,882	1.00
1.01	CAP REL COSTS-BLDG & FIXT NEW BDG EX	16,280,409	0	16,280,409	0.363144	36,803	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	6,927,504	0	6,927,504	0.154522	15,660	2.00
3.00	Total (sum of lines 1-2)	44,831,799	0	44,831,799	1.000000	101,345	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	48,882	1,035,652	2,475	1.00
1.01	CAP REL COSTS-BLDG & FIXT NEW BDG EX	0	0	36,803	826,382	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	15,660	690,800	52,844	2.00
3.00	Total (sum of lines 1-2)	0	0	101,345	2,552,834	55,319	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	48,882	0	0	1,087,009	1.00
1.01	CAP REL COSTS-BLDG & FIXT NEW BDG EX	0	36,803	0	0	863,185	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	15,660	0	0	759,304	2.00
3.00	Total (sum of lines 1-2)	0	101,345	0	0	2,709,498	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/22/2024 9:54 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT NEW BDG EX (chapter 2)	B	-246,781	CAP REL COSTS-BLDG & FIXT NEW BDG EX	1.01	11	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-11,652	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-4,629	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,356,871			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-73,725	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	-7,981	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	-113	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT NEW BDG EX		0	CAP REL COSTS-BLDG & FIXT NEW BDG EX	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	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)	A	-1,878	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/22/2024 9:54 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-22,190	OTHER ADMIN AND GENERAL	5.04	0	33.00
33.01	MISCELLANEOUS INCOME	B	-25,695	RURAL HEALTH CLINIC	88.00	0	33.01
34.00	SPORTS MEDICINE INCOME	B	-3,500	PHYSICAL THERAPY	66.00	0	34.00
35.00	ADVERTISING	A	-61,598	OTHER ADMIN AND GENERAL	5.04	0	35.00
36.00	PATIENT PHONE COSTS - CAPITAL	A	-44	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.00
36.01	PATIENT PHONE COSTS - BENEFITS	A	-938	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.01
36.02	PATIENT PHONE COSTS - SALARY	A	-3,290	NONPATIENT TELEPHONES	5.01	0	36.02
36.03	PATIENT PHONE COSTS - OTHER	A	-4,892	NONPATIENT TELEPHONES	5.01	0	36.03
38.00	SELF-INS CASH PMNTS TO HOSPITAL	A	-611,224	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	PHYSICIAN RECRUITMENT	A	-349	OTHER ADMIN AND GENERAL	5.04	0	39.00
40.00	HOSPICE COSTS	A	1,878	HOSPICE	116.00	0	40.00
41.00	LOBBYING	A	-11,668	OTHER ADMIN AND GENERAL	5.04	0	41.00
44.00	MEDICAID TAX	A	-676,292	OTHER ADMIN AND GENERAL	5.04	0	44.00
45.00	GOODWILL AMORTIZATION	A	-25,809	OTHER ADMIN AND GENERAL	5.04	0	45.00
45.01	PHYSICIAN BENEFITS - HOSP & PODIATRY	A	-12,591	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.01
45.02	340B RETAIL PHARMACY COSTS	A	-31,419	PHARMACY	15.00	0	45.02
45.03	RHC NON-ALLOWABLE CONTRACT PHYSICIAN	A	0	RURAL HEALTH CLINIC	88.00	0	45.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,193,251				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/22/2024 9:54 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	36,000	6,686	29,314	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	56,670	56,670	0	0	0	2.00
3.00	91.00	EMERGENCY	2,004,459	1,071,331	933,128	0	0	3.00
4.00	50.00	OPERATING ROOM	757,189	757,189	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	464,995	464,995	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,319,313	2,356,871	962,442		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	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	6,686		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	56,670		2.00
3.00	91.00	EMERGENCY	0	0	0	1,071,331		3.00
4.00	50.00	OPERATING ROOM	0	0	0	757,189		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	464,995		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,356,871		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/22/2024 9:54 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	BLDG & FIXT NEW BDG EX	MVBLE EQUIP		
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,087,009	1,087,009				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX	863,185	0	863,185			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	759,304			759,304		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,457,435	0	0	0	4,457,435	4.00
5.01	00540	NONPATIENT TELEPHONES	145,358	1,302	0	663	14,067	5.01
5.02	00550	DATA PROCESSING	596,045	23,540	4,182	47,914	115,615	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	853,602	35,864	0	4,299	162,795	5.03
5.04	00590	OTHER ADMIN AND GENERAL	2,165,865	135,452	46,773	12,251	317,493	5.04
7.00	00700	OPERATION OF PLANT	1,155,334	327,763	310,270	17,658	79,677	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	60,439	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	422,209	15,365	2,491	3,309	108,395	9.00
10.00	01000	DIETARY	84,490	16,071	50,926	9,302	12,697	10.00
11.00	01100	CAFETERIA	233,571	0	31,202	0	46,196	11.00
13.00	01300	NURSING ADMINISTRATION	477,902	2,713	0	0	133,281	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	54,788	1,290	29,778	0	13,402	14.00
15.00	01500	PHARMACY	322,879	7,859	0	28,858	75,930	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	207,209	7,458	0	1,411	49,313	16.00
17.00	01700	SOCIAL SERVICE	136,738	2,616	0	391	35,845	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	368,050	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,124,400	81,230	0	28,688	291,769	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,136,678	0	264,801	154,708	200,810	50.00
53.00	05300	ANESTHESIOLOGY	35,850	0	0	18,069	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,442,795	23,553	49,443	260,353	198,624	54.00
60.00	06000	LABORATORY	1,327,601	4,319	47,485	52,304	221,511	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	706,077	31,399	25,834	26,395	172,587	65.00
66.00	06600	PHYSICAL THERAPY	839,019	112,970	0	22,860	222,871	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	50,855	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	423,698	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	990,839	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,770,175	54,417	0	5,006	619,374	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,522,134	28,626	0	0	298,418	88.01
88.02	08802	RURAL HEALTH CLINIC III	416,228	15,535	0	4,286	105,696	88.02
91.00	09100	EMERGENCY	2,348,922	47,227	0	25,748	362,291	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,378,959	47,495	0	25,518	309,115	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	538,137	0	0	6,990	100,950	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,503,779	1,024,064	863,185	756,981	4,268,722	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	4,489	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	309,523	55,658	0	0	75,278	192.00
194.00	07950	HOMEBOUND MEALS	144,483	0	0	0	21,712	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	131,863	0	0	1,746	33,828	194.01
194.02	07952	FOUNDATION	61,567	2,798	0	0	17,232	194.02
194.03	07953	MOWEAQUA THERAPY	163,808	0	0	577	40,663	194.03
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)	32,315,023	1,087,009	863,185	759,304	4,457,435	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/22/2024 9:54 am

		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	
			5.01	5.02	5.03	5A.03	5.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	161,390					5.01
5.02	00550	DATA PROCESSING	21,843	809,139				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	11,528	60,331	1,128,419			5.03
5.04	00590	OTHER ADMIN AND GENERAL	10,314	42,586	0	2,730,734	2,730,734	5.04
7.00	00700	OPERATION OF PLANT	1,820	10,647	0	1,903,169	175,670	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	60,439	5,579	8.00
9.00	00900	HOUSEKEEPING	607	3,549	0	555,925	51,314	9.00
10.00	01000	DIETARY	1,820	7,098	0	182,404	16,837	10.00
11.00	01100	CAFETERIA	0	0	0	310,969	28,704	11.00
13.00	01300	NURSING ADMINISTRATION	1,820	10,647	0	626,363	57,816	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	607	3,549	0	103,414	9,546	14.00
15.00	01500	PHARMACY	1,820	14,195	0	451,541	41,679	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,034	14,195	0	282,620	26,087	16.00
17.00	01700	SOCIAL SERVICE	1,213	7,098	0	183,901	16,975	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	368,050	33,972	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,955	24,842	34,951	1,599,835	147,671	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,640	35,489	113,076	1,909,202	176,227	50.00
53.00	05300	ANESTHESIOLOGY	607	7,098	27,321	88,945	8,210	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,067	42,586	314,629	2,338,050	215,811	54.00
60.00	06000	LABORATORY	6,067	35,489	204,629	1,899,405	175,323	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	7,281	31,940	52,948	1,054,461	97,331	65.00
66.00	06600	PHYSICAL THERAPY	9,101	42,586	65,208	1,314,615	121,344	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	7,461	58,316	5,383	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	9,599	433,297	39,995	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	87,815	1,078,654	99,564	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	20,022	102,915	48,537	3,620,446	334,169	88.00
88.01	08801	RURAL HEALTH CLINIC II	9,708	92,270	17,040	1,968,196	181,672	88.01
88.02	08802	RURAL HEALTH CLINIC III	3,640	24,842	8,308	578,535	53,401	88.02
91.00	09100	EMERGENCY	8,494	39,037	119,789	2,951,508	272,436	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	9,101	46,135	0	1,816,323	167,654	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	78,075	0	724,152	66,842	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	154,109	777,199	1,111,311	31,193,469	2,627,212	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	4,489	414	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,854	17,744	5,516	468,573	43,251	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	166,195	15,340	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	1,213	7,098	0	175,748	16,222	194.01
194.02	07952	FOUNDATION	607	3,549	0	85,753	7,915	194.02
194.03	07953	MOWEAQUA THERAPY	607	3,549	11,592	220,796	20,380	194.03
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)	161,390	809,139	1,128,419	32,315,023	2,730,734	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/22/2024 9:54 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT	2,078,839					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	66,018				8.00
9.00	00900	HOUSEKEEPING	44,301	0	651,540			9.00
10.00	01000	DIETARY	99,915	0	33,011	332,167		10.00
11.00	01100	CAFETERIA	34,599	0	11,431	0	385,703	11.00
13.00	01300	NURSING ADMINISTRATION	7,334	0	2,423	0	11,341	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	36,506	0	12,061	0	4,383	14.00
15.00	01500	PHARMACY	21,246	0	7,019	0	8,129	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,161	0	6,661	0	10,136	16.00
17.00	01700	SOCIAL SERVICE	7,071	0	2,336	0	6,257	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	3,547	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	219,595	18,383	72,553	332,167	38,942	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	293,627	8,048	97,012	0	31,247	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	118,497	7,888	39,150	0	33,523	54.00
60.00	06000	LABORATORY	64,330	0	21,254	0	32,886	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	113,531	433	37,510	0	28,570	65.00
66.00	06600	PHYSICAL THERAPY	305,399	3,367	100,903	0	32,384	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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	147,110	0	48,604	0	63,430	88.00
88.01	08801	RURAL HEALTH CLINIC II	77,386	6	25,568	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	41,998	0	0	0	0	88.02
91.00	09100	EMERGENCY	127,673	21,395	42,182	0	49,848	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	128,396	0	35,641	0	12,311	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	3,346	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,908,675	59,520	595,319	332,167	370,280	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	12,136	0	4,010	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	150,464	0	49,712	0	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	4,848	0	0	12,010	194.01
194.02	07952	FOUNDATION	7,564	0	2,499	0	3,413	194.02
194.03	07953	MOWEAQUA THERAPY	0	1,650	0	0	0	194.03
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)	2,078,839	66,018	651,540	332,167	385,703	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/22/2024 9:54 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	705,277					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	165,910				14.00
15.00	01500	PHARMACY	21,206	365	551,185			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,976	0	349,641		16.00
17.00	01700	SOCIAL SERVICE	16,322	2	0	0	232,864	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	9,252	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	101,589	26,169	0	11,276	186,291	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	81,515	24,544	0	36,481	0	50.00
53.00	05300	ANESTHESIOLOGY	0	7,349	0	8,814	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,453	4,317	0	101,537	0	54.00
60.00	06000	LABORATORY	85,791	3,238	0	66,018	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	74,533	5,264	0	17,082	0	65.00
66.00	06600	PHYSICAL THERAPY	84,482	1,080	0	21,037	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,407	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	3,097	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	551,185	28,331	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	13,678	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,177	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	968	0	0	0	88.02
91.00	09100	EMERGENCY	130,043	62,408	0	38,646	46,573	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	6,801	0	7,096	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	273	0	4,079	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	692,186	164,609	551,185	345,901	232,864	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	837	0	0	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	464	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	MOWEAQUA THERAPY	13,091	0	0	3,740	0	194.03
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)	705,277	165,910	551,185	349,641	232,864	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/22/2024 9:54 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	414,821					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,754,471	-48,597	2,705,874		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,657,903	0	2,657,903		50.00
53.00	05300	ANESTHESIOLOGY	414,821	528,139	0	528,139		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,946,226	0	2,946,226		54.00
60.00	06000	LABORATORY	0	2,348,245	0	2,348,245		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	48,597	48,597		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,428,715	0	1,428,715		65.00
66.00	06600	PHYSICAL THERAPY	0	1,984,611	0	1,984,611		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	66,106	0	66,106		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	476,389	0	476,389		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,757,734	0	1,757,734		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,227,437	0	4,227,437		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,257,005	0	2,257,005		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	674,902	0	674,902		88.02
91.00	09100	EMERGENCY	0	3,742,712	0	3,742,712		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,174,222	0	2,174,222		101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE		798,692	0	798,692		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	414,821	30,823,509	0	30,823,509		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	21,049	0	21,049		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	712,837	0	712,837		192.00
194.00	07950	HOMEBOUND MEALS	0	181,535	0	181,535		194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	209,292	0	209,292		194.01
194.02	07952	FOUNDATION	0	107,144	0	107,144		194.02
194.03	07953	MOWEAQUA THERAPY	0	259,657	0	259,657		194.03
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	414,821	32,315,023	0	32,315,023		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/22/2024 9:54 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS BLDG & FIXT NEW BDG EX	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	1,302	0	663	1,965	5.01
5.02	00550	DATA PROCESSING	0	23,540	4,182	47,914	75,636	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	825	35,864	0	4,299	40,988	5.03
5.04	00590	OTHER ADMIN AND GENERAL	1,640	135,452	46,773	12,251	196,116	5.04
7.00	00700	OPERATION OF PLANT	1,800	327,763	310,270	17,658	657,491	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	15,365	2,491	3,309	21,165	9.00
10.00	01000	DIETARY	0	16,071	50,926	9,302	76,299	10.00
11.00	01100	CAFETERIA	0	0	31,202	0	31,202	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,713	0	0	2,713	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,290	29,778	0	31,068	14.00
15.00	01500	PHARMACY	1,256	7,859	0	28,858	37,973	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,458	0	1,411	8,869	16.00
17.00	01700	SOCIAL SERVICE	0	2,616	0	391	3,007	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	81,230	0	28,688	109,918	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	89,467	0	264,801	154,708	508,976	50.00
53.00	05300	ANESTHESIOLOGY	1,382	0	0	18,069	19,451	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,553	49,443	260,353	333,349	54.00
60.00	06000	LABORATORY	0	4,319	47,485	52,304	104,108	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,254	31,399	25,834	26,395	88,882	65.00
66.00	06600	PHYSICAL THERAPY	0	112,970	0	22,860	135,830	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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	54,417	0	5,006	59,423	88.00
88.01	08801	RURAL HEALTH CLINIC II	12,000	28,626	0	0	40,626	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	15,535	0	4,286	19,821	88.02
91.00	09100	EMERGENCY	0	47,227	0	25,748	72,975	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	9,400	47,495	0	25,518	82,413	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	4,442	0	0	6,990	11,432	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	127,466	1,024,064	863,185	756,981	2,771,696	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	4,489	0	0	4,489	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	55,658	0	0	55,658	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	0	0	1,746	1,746	194.01
194.02	07952	FOUNDATION	0	2,798	0	0	2,798	194.02
194.03	07953	MOWEAQUA THERAPY	12,987	0	0	577	13,564	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	140,453	1,087,009	863,185	759,304	2,849,951	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/22/2024 9:54 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMIN AND GENERAL	
			4.00	5.01	5.02	5.03	5.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.01	00540	NONPATIENT TELEPHONES	0	1,965				5.01
5.02	00550	DATA PROCESSING	0	268	75,904			5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	140	5,660	46,788		5.03
5.04	00590	OTHER ADMIN AND GENERAL	0	126	3,995	0	200,237	5.04
7.00	00700	OPERATION OF PLANT	0	22	999	0	12,881	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	409	8.00
9.00	00900	HOUSEKEEPING	0	7	333	0	3,763	9.00
10.00	01000	DIETARY	0	22	666	0	1,235	10.00
11.00	01100	CAFETERIA	0	0	0	0	2,105	11.00
13.00	01300	NURSING ADMINISTRATION	0	22	999	0	4,239	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7	333	0	700	14.00
15.00	01500	PHARMACY	0	22	1,332	0	3,056	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	37	1,332	0	1,913	16.00
17.00	01700	SOCIAL SERVICE	0	15	666	0	1,245	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	2,491	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	170	2,330	1,449	10,828	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	44	3,329	4,688	12,921	50.00
53.00	05300	ANESTHESIOLOGY	0	7	666	1,133	602	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	74	3,995	13,050	15,824	54.00
60.00	06000	LABORATORY	0	74	3,329	8,484	12,855	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	89	2,996	2,195	7,137	65.00
66.00	06600	PHYSICAL THERAPY	0	111	3,995	2,703	8,897	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	309	395	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	398	2,933	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,641	7,300	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	244	9,652	2,012	24,512	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	118	8,656	706	13,321	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	44	2,330	344	3,916	88.02
91.00	09100	EMERGENCY	0	103	3,662	4,966	19,976	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	111	4,328	0	12,293	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	7,324	0	4,901	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,877	72,907	46,078	192,648	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	30	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	59	1,665	229	3,171	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	1,125	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	15	666	0	1,189	194.01
194.02	07952	FOUNDATION	0	7	333	0	580	194.02
194.03	07953	MOWEAQUA THERAPY	0	7	333	481	1,494	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,965	75,904	46,788	200,237	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/22/2024 9:54 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT	671,393					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	409				8.00
9.00	00900	HOUSEKEEPING	14,308	0	39,576			9.00
10.00	01000	DIETARY	32,269	0	2,005	112,496		10.00
11.00	01100	CAFETERIA	11,174	0	694	0	45,175	11.00
13.00	01300	NURSING ADMINISTRATION	2,369	0	147	0	1,328	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,790	0	733	0	513	14.00
15.00	01500	PHARMACY	6,862	0	426	0	952	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,511	0	405	0	1,187	16.00
17.00	01700	SOCIAL SERVICE	2,284	0	142	0	733	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	415	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	70,922	114	4,407	112,496	4,561	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	94,831	50	5,893	0	3,660	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,270	49	2,378	0	3,926	54.00
60.00	06000	LABORATORY	20,776	0	1,291	0	3,852	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	36,666	3	2,278	0	3,346	65.00
66.00	06600	PHYSICAL THERAPY	98,635	21	6,129	0	3,793	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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	47,511	0	2,952	0	7,430	88.00
88.01	08801	RURAL HEALTH CLINIC II	24,993	0	1,553	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	13,564	0	0	0	0	88.02
91.00	09100	EMERGENCY	41,234	132	2,562	0	5,838	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	41,467	0	2,165	0	1,442	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	392	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	616,436	369	36,160	112,496	43,368	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	3,919	0	244	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	48,595	0	3,020	0	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	30	0	0	1,407	194.01
194.02	07952	FOUNDATION	2,443	0	152	0	400	194.02
194.03	07953	MOWEAQUA THERAPY	0	10	0	0	0	194.03
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)	671,393	409	39,576	112,496	45,175	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/22/2024 9:54 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	11,817					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	45,144				14.00
15.00	01500	PHARMACY	355	99	51,077			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,082	0	21,336		16.00
17.00	01700	SOCIAL SERVICE	273	1	0	0	8,366	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	155	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,702	7,121	0	687	6,693	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,366	6,678	0	2,223	0	50.00
53.00	05300	ANESTHESIOLOGY	0	2,000	0	537	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,465	1,175	0	6,218	0	54.00
60.00	06000	LABORATORY	1,437	881	0	4,022	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,249	1,432	0	1,041	0	65.00
66.00	06600	PHYSICAL THERAPY	1,416	294	0	1,282	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	147	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	189	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	51,077	1,726	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,722	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,136	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	263	0	0	0	88.02
91.00	09100	EMERGENCY	2,180	16,981	0	2,355	1,673	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,851	0	432	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	74	0	249	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,598	44,790	51,077	21,108	8,366	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	228	0	0	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	126	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	MOWEAQUA THERAPY	219	0	0	228	0	194.03
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)	11,817	45,144	51,077	21,336	8,366	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/22/2024 9:54 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	3,061					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		333,398	0	333,398		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		644,659	0	644,659		50.00
53.00	05300	ANESTHESIOLOGY		24,396	0	24,396		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		419,773	0	419,773		54.00
60.00	06000	LABORATORY		161,109	0	161,109		60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY		147,314	0	147,314		65.00
66.00	06600	PHYSICAL THERAPY		263,106	0	263,106		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		851	0	851		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS		3,520	0	3,520		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		63,744	0	63,744		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		157,458	0	157,458		88.00
88.01	08801	RURAL HEALTH CLINIC II		91,109	0	91,109		88.01
88.02	08802	RURAL HEALTH CLINIC III		40,282	0	40,282		88.02
91.00	09100	EMERGENCY		174,637	0	174,637		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY		146,502	0	146,502		101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE		24,372	0	24,372		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,696,230	0	2,696,230		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN		8,682	0	8,682		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		112,625	0	112,625		192.00
194.00	07950	HOMEBOUND MEALS		1,125	0	1,125		194.00
194.01	07951	FITNESS WELLNESS PROGRAM		5,179	0	5,179		194.01
194.02	07952	FOUNDATION		6,713	0	6,713		194.02
194.03	07953	MOWEAQUA THERAPY		16,336	0	16,336		194.03
200.00		Cross Foot Adjustments	3,061	3,061	0	3,061		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,061	2,849,951	0	2,849,951		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/22/2024 9:54 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT NEW BDG EX (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (# OF PHONE S)	
			1.00	1.01	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	89,351					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX	0	29,103				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			743,644			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	15,269,607		4.00
5.01	00540	NONPATIENT TELEPHONES	107	0	649	48,190	266	5.01
5.02	00550	DATA PROCESSING	1,935	141	46,926	396,055	36	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,948	0	4,210	557,679	19	5.03
5.04	00590	OTHER ADMIN AND GENERAL	11,134	1,577	11,998	1,087,617	17	5.04
7.00	00700	OPERATION OF PLANT	26,942	10,461	17,294	272,946	3	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,263	84	3,241	371,321	1	9.00
10.00	01000	DIETARY	1,321	1,717	9,110	43,495	3	10.00
11.00	01100	CAFETERIA	0	1,052	0	158,250	0	11.00
13.00	01300	NURSING ADMINISTRATION	223	0	0	456,574	3	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	106	1,004	0	45,912	1	14.00
15.00	01500	PHARMACY	646	0	28,263	260,110	3	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	613	0	1,382	168,929	5	16.00
17.00	01700	SOCIAL SERVICE	215	0	383	122,793	2	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,677	0	28,096	999,497	23	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	8,928	151,517	687,905	6	50.00
53.00	05300	ANESTHESIOLOGY	0	0	17,696	0	1	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,936	1,667	254,983	680,414	10	54.00
60.00	06000	LABORATORY	355	1,601	51,225	758,817	10	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,581	871	25,851	591,222	12	65.00
66.00	06600	PHYSICAL THERAPY	9,286	0	22,389	763,478	15	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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	4,473	0	4,903	2,121,780	33	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,353	0	0	1,022,274	16	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,277	0	4,198	362,077	6	88.02
91.00	09100	EMERGENCY	3,882	0	25,217	1,241,078	14	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,904	0	24,992	1,058,917	15	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	6,846	345,817	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	84,177	29,103	741,369	14,623,147	254	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	369	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,575	0	0	257,874	8	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	74,378	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	0	1,710	115,881	2	194.01
194.02	07952	FOUNDATION	230	0	0	59,030	1	194.02
194.03	07953	MOWEAQUA THERAPY	0	0	565	139,297	1	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,087,009	863,185	759,304	4,457,435	161,390	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.165605	29.659657	1.021058	0.291916	606.729323	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0	1,965	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000	7.387218	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: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/22/2024 9:54 am

		Cost Center Description	DATA PROCESSING (# OF TERMINALS)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.02	5.03	5A.04	5.04	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	228					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	17	75,702,326				5.03
5.04	00590	OTHER ADMIN AND GENERAL	12	0	-2,730,734	29,584,289		5.04
7.00	00700	OPERATION OF PLANT	3	0	0	1,903,169	63,209	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	60,439	0	8.00
9.00	00900	HOUSEKEEPING	1	0	0	555,925	1,347	9.00
10.00	01000	DIETARY	2	0	0	182,404	3,038	10.00
11.00	01100	CAFETERIA	0	0	0	310,969	1,052	11.00
13.00	01300	NURSING ADMINISTRATION	3	0	0	626,363	223	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1	0	0	103,414	1,110	14.00
15.00	01500	PHARMACY	4	0	0	451,541	646	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4	0	0	282,620	613	16.00
17.00	01700	SOCIAL SERVICE	2	0	0	183,901	215	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	368,050	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7	2,344,775	0	1,599,835	6,677	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10	7,585,969	0	1,909,202	8,928	50.00
53.00	05300	ANESTHESIOLOGY	2	1,832,891	0	88,945	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12	21,107,670	0	2,338,050	3,603	54.00
60.00	06000	LABORATORY	10	13,727,936	0	1,899,405	1,956	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	9	3,552,098	0	1,054,461	3,452	65.00
66.00	06600	PHYSICAL THERAPY	12	4,374,590	0	1,314,615	9,286	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	500,504	0	58,316	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	643,937	0	433,297	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,891,278	0	1,078,654	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	29	3,256,193	0	3,620,446	4,473	88.00
88.01	08801	RURAL HEALTH CLINIC II	26	1,143,148	0	1,968,196	2,353	88.01
88.02	08802	RURAL HEALTH CLINIC III	7	557,353	0	578,535	1,277	88.02
91.00	09100	EMERGENCY	11	8,036,285	0	2,951,508	3,882	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	13	0	0	1,816,323	3,904	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	22	0	0	724,152	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	219	74,554,627	-2,730,734	28,462,735	58,035	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	4,489	369	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5	370,058	0	468,573	4,575	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	166,195	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	2	0	0	175,748	0	194.01
194.02	07952	FOUNDATION	1	0	0	85,753	230	194.02
194.03	07953	MOWEAQUA THERAPY	1	777,641	0	220,796	0	194.03
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)	809,139	1,128,419		2,730,734	2,078,839	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3,548.855263	0.014906		0.092304	32.888339	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	75,904	46,788		200,237	671,393	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	332.912281	0.000618		0.006768	10.621794	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: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/22/2024 9:54 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HR)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	105,284					8.00
9.00	00900	HOUSEKEEPING	0	59,961				9.00
10.00	01000	DIETARY	0	3,038	4,911			10.00
11.00	01100	CAFETERIA	0	1,052	0	239,802		11.00
13.00	01300	NURSING ADMINISTRATION	0	223	0	7,051	168,084	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,110	0	2,725	0	14.00
15.00	01500	PHARMACY	0	646	0	5,054	5,054	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	613	0	6,302	0	16.00
17.00	01700	SOCIAL SERVICE	0	215	0	3,890	3,890	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	2,205	2,205	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,317	6,677	4,911	24,211	24,211	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,835	8,928	0	19,427	19,427	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,579	3,603	0	20,842	20,842	54.00
60.00	06000	LABORATORY	0	1,956	0	20,446	20,446	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	690	3,452	0	17,763	17,763	65.00
66.00	06600	PHYSICAL THERAPY	5,369	9,286	0	20,134	20,134	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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	4,473	0	39,437	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	10	2,353	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	34,121	3,882	0	30,992	30,992	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	3,280	0	7,654	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	2,080	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	94,921	54,787	4,911	230,213	164,964	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	369	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,575	0	0	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	7,732	0	0	7,467	0	194.01
194.02	07952	FOUNDATION	0	230	0	2,122	0	194.02
194.03	07953	MOWEAQUA THERAPY	2,631	0	0	0	3,120	194.03
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)	66,018	651,540	332,167	385,703	705,277	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.627047	10.866063	67.637345	1.608423	4.195979	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	409	39,576	112,496	45,175	11,817	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003885	0.660029	22.906944	0.188385	0.070304	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: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/22/2024 9:54 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			14.00	15.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	90,013					14.00
15.00	01500	PHARMACY	198	990,839				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,157	0	72,699,177			16.00
17.00	01700	SOCIAL SERVICE	1	0	0	100		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,198	0	2,344,775	80	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,316	0	7,585,969	0	0	50.00
53.00	05300	ANESTHESIOLOGY	3,987	0	1,832,891	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,342	0	21,107,670	0	0	54.00
60.00	06000	LABORATORY	1,757	0	13,727,936	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,856	0	3,552,098	0	0	65.00
66.00	06600	PHYSICAL THERAPY	586	0	4,374,590	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	500,504	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	643,937	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	990,839	5,891,278	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,421	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,266	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	525	0	0	0	0	88.02
91.00	09100	EMERGENCY	33,859	0	8,036,285	20	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,690	0	1,475,474	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	148	0	848,129	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	89,307	990,839	71,921,536	100	100	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	454	0	0	0	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	252	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	MOWEAQUA THERAPY	0	0	777,641	0	0	194.03
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)	165,910	551,185	349,641	232,864	414,821	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.843178	0.556281	0.004809	2,328.640000	4,148.210000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	45,144	51,077	21,336	8,366	3,061	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.501528	0.051549	0.000293	83.660000	30.610000	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

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-2 | Date/Time Prepared: 5/22/2024 9:54 am

		Description	Worksheet CODE	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		IV THERAPY	1	30.00	-48,597	7.00
8.00		IV THERAPY	1	64.00	48,597	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/22/2024 9:54 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,705,874		2,705,874	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,657,903		2,657,903	0	0	50.00
53.00	05300	ANESTHESIOLOGY	528,139		528,139	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,946,226		2,946,226	0	0	54.00
60.00	06000	LABORATORY	2,348,245		2,348,245	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	48,597		48,597	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,428,715	0	1,428,715	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,984,611	0	1,984,611	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	66,106		66,106	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	476,389		476,389	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,757,734		1,757,734	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,227,437		4,227,437	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,257,005		2,257,005	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	674,902		674,902	0	0	88.02
91.00	09100	EMERGENCY	3,742,712		3,742,712	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	157,325		157,325		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,174,222		2,174,222		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	798,692		798,692		0	116.00
200.00		Subtotal (see instructions)	30,980,834	0	30,980,834	0	0	200.00
201.00		Less Observation Beds	157,325		157,325		0	201.00
202.00		Total (see instructions)	30,823,509	0	30,823,509	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/22/2024 9:54 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,796,386		1,796,386			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,247	7,339,677	7,350,924	0.361574	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	16,034	1,761,887	1,777,921	0.297054	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	414,056	20,321,215	20,735,271	0.142088	0.000000	54.00
60.00	06000	LABORATORY	522,890	13,001,777	13,524,667	0.173627	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	11,958	407,018	418,976	0.115990	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,126,306	2,390,109	3,516,415	0.406299	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	971,569	3,340,948	4,312,517	0.460198	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	132,531	350,340	482,871	0.136902	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	628,936	628,936	0.757452	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	807,947	5,031,565	5,839,512	0.301007	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,256,193	3,256,193			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,143,148	1,143,148			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	557,353	557,353			88.02
91.00	09100	EMERGENCY	50,012	7,893,307	7,943,319	0.471177	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,040	119,831	121,871	1.290914	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,475,474	1,475,474			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	848,129	848,129			116.00
200.00		Subtotal (see instructions)	5,862,976	69,866,907	75,729,883			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,862,976	69,866,907	75,729,883			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/22/2024 9:54 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/22/2024 9:54 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	644,659	7,350,924	0.087698	6,424	563	50.00
53.00	05300	ANESTHESIOLOGY	24,396	1,777,921	0.013722	1,514	21	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	419,773	20,735,271	0.020244	162,490	3,289	54.00
60.00	06000	LABORATORY	161,109	13,524,667	0.011912	196,876	2,345	60.00
64.00	06400	INTRAVENOUS THERAPY	0	418,976	0.000000	2,994	0	64.00
65.00	06500	RESPIRATORY THERAPY	147,314	3,516,415	0.041893	338,729	14,190	65.00
66.00	06600	PHYSICAL THERAPY	263,106	4,312,517	0.061010	70,152	4,280	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	851	482,871	0.001762	55,844	98	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	3,520	628,936	0.005597	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	63,744	5,839,512	0.010916	210,615	2,299	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	157,458	3,256,193	0.048356	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	91,109	1,143,148	0.079700	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	40,282	557,353	0.072274	0	0	88.02
91.00	09100	EMERGENCY	174,637	7,943,319	0.021985	1,006	22	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	19,384	121,871	0.159053	106	17	92.00
200.00		Total (lines 50 through 199)	2,211,342	71,609,894		1,046,750	27,124	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/22/2024 9:54 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	414,821	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	414,821	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/22/2024 9:54 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	7,350,924	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	414,821	0	1,777,921	0.233318	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,735,271	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	13,524,667	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	418,976	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,516,415	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,312,517	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	482,871	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	628,936	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,839,512	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,256,193	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,143,148	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	557,353	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	7,943,319	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	121,871	0.000000	92.00
200.00		Total (lines 50 through 199)	0	414,821	0	71,609,894		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/22/2024 9:54 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	6,424	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,514	353	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	162,490	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	196,876	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	2,994	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	338,729	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	70,152	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	55,844	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	210,615	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
91.00	09100	EMERGENCY	0.000000	1,006	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	106	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,046,750	353	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/22/2024 9:54 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.361574	0	1,728,721	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.297054	0	443,556	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142088	0	6,543,322	0	0	54.00
60.00	06000	LABORATORY	0.173627	0	3,716,862	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.115990	0	168,962	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.406299	0	1,025,898	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.460198	0	1,263,084	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.136902	0	129,454	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.757452	0	167,613	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.301007	0	2,988,565	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
91.00	09100	EMERGENCY	0.471177	0	2,439,054	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.290914	0	51,675	0	0	92.00
200.00		Subtotal (see instructions)		0	20,666,766	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	20,666,766	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/22/2024 9:54 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	625,061	0		50.00
53.00	05300	ANESTHESIOLOGY	131,760	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	929,728	0		54.00
60.00	06000	LABORATORY	645,348	0		60.00
64.00	06400	INTRAVENOUS THERAPY	19,598	0		64.00
65.00	06500	RESPIRATORY THERAPY	416,821	0		65.00
66.00	06600	PHYSICAL THERAPY	581,269	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,723	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	126,959	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	899,579	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
91.00	09100	EMERGENCY	1,149,226	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	66,708	0		92.00
200.00		Subtotal (see instructions)	5,609,780	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,609,780	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/22/2024 9:54 am

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)	1,739	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	716	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)	616	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,001	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	22	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)	336	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)	907	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	208.70	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,705,874	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)	4,591	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)	1,579,424	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,126,450	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)	1,126,450	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)	1,573.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	528,615	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)	528,615	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/22/2024 9:54 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	301,953	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)	830,568	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)	1,426,947	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	1,426,947	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)	100	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,573.25	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	157,325	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/22/2024 9:54 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	333,398	2,705,874	0.123213	157,325	19,384	90.00
91.00	Nursing Program cost	0	2,705,874	0.000000	157,325	0	91.00
92.00	Allied health cost	0	2,705,874	0.000000	157,325	0	92.00
93.00	All other Medical Education	0	2,705,874	0.000000	157,325	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/22/2024 9:54 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		440,806		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.361574	6,424	2,323	50.00
53.00	05300	ANESTHESIOLOGY	0.297054	1,514	450	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142088	162,490	23,088	54.00
60.00	06000	LABORATORY	0.173627	196,876	34,183	60.00
64.00	06400	INTRAVENOUS THERAPY	0.115990	2,994	347	64.00
65.00	06500	RESPIRATORY THERAPY	0.406299	338,729	137,625	65.00
66.00	06600	PHYSICAL THERAPY	0.460198	70,152	32,284	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.136902	55,844	7,645	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.757452	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.301007	210,615	63,397	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	09100	EMERGENCY	0.471177	1,006	474	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.290914	106	137	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,046,750	301,953	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)		1,046,750		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3

Component CCN: 14-Z341 | Date/Time Prepared: 5/22/2024 9:54 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.361574	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.297054	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142088	74,487	10,584	54.00
60.00	06000	LABORATORY	0.173627	129,487	22,482	60.00
64.00	06400	INTRAVENOUS THERAPY	0.115990	998	116	64.00
65.00	06500	RESPIRATORY THERAPY	0.406299	419,550	170,463	65.00
66.00	06600	PHYSICAL THERAPY	0.460198	719,818	331,259	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.136902	32,420	4,438	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.757452	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.301007	379,758	114,310	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	09100	EMERGENCY	0.471177	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.290914	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,756,518	653,652	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)		1,756,518		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1341	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/22/2024 9:54 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,609,780	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)	5,609,780	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)	5,665,878	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)	42,290	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,336,017	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,287,571	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)	2,287,571	30.00
31.00	Primary payer payments	709	31.00
32.00	Subtotal (line 30 minus line 31)	2,286,862	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)	428,626	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	278,607	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	428,626	36.00
37.00	Subtotal (see instructions)	2,565,469	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,565,469	40.00
40.01	Sequestration adjustment (see instructions)	51,309	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	3,036,557	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)	-522,397	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1341	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/22/2024 9:54 am
	Title XVIII	Hospital	Cost

			1.00	
94.00	Total (sum of lines 91 and 93)		0	94.00
			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: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 5/22/2024 9:54 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,063,609		3,026,942	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	07/19/2023	90,266	07/19/2023	9,782	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	12/06/2023	216,849	12/06/2023	167	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)		-126,583		9,615	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)		937,026		3,036,557	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		235,739		522,397	6.02
7.00	Total Medicare program liability (see instructions)		701,287		2,514,160	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: 14-1341 | Component CCN: 14-Z341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/22/2024 9:54 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,232,920		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	07/19/2023	55,333		0	3.01
3.02		12/06/2023	35,281		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)		90,614		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)		2,323,534		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		298,261		0	6.02
7.00	Total Medicare program liability (see instructions)		2,025,273		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: 14-1341	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/22/2024 9:54 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-1341 | Component CCN: 14-Z341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/22/2024 9:54 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,441,216	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)	660,189	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	907	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)	2,101,405	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,101,405	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)	2,101,405	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	34,800	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	2,066,605	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)	2,066,605	0	19.00
19.01	Sequestration adjustment (see instructions)	41,332	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	2,323,534	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)	-298,261	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: 14-1341	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/22/2024 9:54 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	830,568	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)	830,568	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	838,874	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)	838,874	19.00
20.00	Deductibles (exclude professional component)	145,336	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	693,538	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	693,538	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	33,940	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	22,061	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	33,940	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	715,599	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)	715,599	30.00
30.01	Sequestration adjustment (see instructions)	14,312	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	937,026	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)	-235,739	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: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/22/2024 9:54 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	17,221,711	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,065,559	0	0	0	4.00
5.00	Other receivable	412,566	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	813,483	0	0	0	7.00
8.00	Prepaid expenses	200,908	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	77,342	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	23,791,569	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	131,721	0	0	0	12.00
13.00	Land improvements	2,846,510	0	0	0	13.00
14.00	Accumulated depreciation	-1,103,277	0	0	0	14.00
15.00	Buildings	32,829,757	0	0	0	15.00
16.00	Accumulated depreciation	-12,521,599	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	2,096,306	0	0	0	19.00
20.00	Accumulated depreciation	-628,712	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	6,927,504	0	0	0	23.00
24.00	Accumulated depreciation	-4,368,135	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	57,245	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	26,267,320	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	6,534,653	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	638,339	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,172,992	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	57,231,881	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,090,921	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,188,220	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	435,579	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	435,701	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,150,421	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,217,144	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,217,144	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,367,565	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	45,864,316				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)	45,864,316	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	57,231,881	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/22/2024 9:54 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		38,785,934		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,168,031				2.00
3.00	Total (sum of line 1 and line 2)		44,953,965		0		3.00
4.00	CHANGE IN NET ASSETS	916,550		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		916,550		0		10.00
11.00	Subtotal (line 3 plus line 10)		45,870,515		0		11.00
12.00	LOOS ON INVESTMETN IN QUAD CTY HMS	6,199		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)		6,199		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		45,864,316		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	CHANGE IN NET ASSETS		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	LOOS ON INVESTMETN IN QUAD CTY HMS		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: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/22/2024 9:54 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	869,816		869,816	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	894,960		894,960	5.00
6.00	Swing bed - NF	34,320		34,320	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)	1,799,096		1,799,096	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)	1,799,096		1,799,096	17.00
18.00	Ancillary services	4,012,149	54,894,178	58,906,327	18.00
19.00	Outpatient services	53,748	8,131,548	8,185,296	19.00
20.00	RURAL HEALTH CLINIC	0	3,256,193	3,256,193	20.00
20.01	RURAL HEALTH CLINIC II	0	1,143,148	1,143,148	20.01
20.02	RURAL HEALTH CLINIC III	0	557,353	557,353	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,475,474	1,475,474	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	848,129	848,129	26.00
27.00	PROFESSIONAL FEES	252,622	9,481,056	9,733,678	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,117,615	79,787,079	85,904,694	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		36,508,274		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)		36,508,274		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/22/2024 9:54 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	85,904,694	1.00
2.00	Less contractual allowances and discounts on patients' accounts	47,553,489	2.00
3.00	Net patient revenues (line 1 minus line 2)	38,351,205	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	36,508,274	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,842,931	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,143,404	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	91,580	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	113	21.00
22.00	Rental of hospital space	54,552	22.00
23.00	Governmental appropriations	22,435	23.00
24.00	RETAIL PHARMACY	120,113	24.00
24.01	FITNESS CENTER REVENUE	63,916	24.01
24.02	MISCELLANEOUS REVENUE	2,828,987	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	4,325,100	25.00
26.00	Total (line 5 plus line 25)	6,168,031	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,168,031	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1341 HHA CCN: 14-7299 | Period: From 01/01/2023 To 12/31/2023 | Worksheet H Date/Time Prepared: 5/22/2024 9:54 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	171,900	0	70,632	0	110,407	352,939	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	513,474	0	0	0	0	513,474	6.00
7.00	Physical Therapy	323,674	0	0	90,205	0	413,879	7.00
8.00	Occupational Therapy	26,571	0	0	17,391	0	43,962	8.00
9.00	Speech Pathology	11,502	0	0	1,782	0	13,284	9.00
10.00	Medical Social Services	7,780	0	0	0	0	7,780	10.00
11.00	Home Health Aide	4,016	0	0	0	0	4,016	11.00
12.00	Supplies (see instructions)	0	0	0	0	29,625	29,625	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,058,917	0	70,632	109,378	140,032	1,378,959	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	352,939	0	352,939			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	513,474	0	513,474			6.00
7.00	Physical Therapy	0	413,879	0	413,879			7.00
8.00	Occupational Therapy	0	43,962	0	43,962			8.00
9.00	Speech Pathology	0	13,284	0	13,284			9.00
10.00	Medical Social Services	0	7,780	0	7,780			10.00
11.00	Home Health Aide	0	4,016	0	4,016			11.00
12.00	Supplies (see instructions)	0	29,625	0	29,625			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	1,378,959	0	1,378,959			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 14-1341 | HHA CCN: 14-7299 | Period: From 01/01/2023 To 12/31/2023 | Worksheet H-1 Part I | Date/Time Prepared: 5/22/2024 9:54 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	352,939	0	0	0	0	352,939	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	513,474	0	0	0	0	513,474	6.00
7.00	Physical Therapy	413,879	0	0	0	0	413,879	7.00
8.00	Occupational Therapy	43,962	0	0	0	0	43,962	8.00
9.00	Speech Pathology	13,284	0	0	0	0	13,284	9.00
10.00	Medical Social Services	7,780	0	0	0	0	7,780	10.00
11.00	Home Health Aide	4,016	0	0	0	0	4,016	11.00
12.00	Supplies (see instructions)	29,625	0	0	0	0	29,625	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,378,959	0	0	0	0	1,378,959	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	352,939			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	176,630	690,104		6.00
7.00	Physical Therapy	142,369	556,248		7.00
8.00	Occupational Therapy	15,122	59,084		8.00
9.00	Speech Pathology	4,570	17,854		9.00
10.00	Medical Social Services	2,676	10,456		10.00
11.00	Home Health Aide	1,381	5,397		11.00
12.00	Supplies (see instructions)	10,191	39,816		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		1,378,959		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-1341 | HHA CCN: 14-7299 | Period: From 01/01/2023 To 12/31/2023 | Worksheet H-1 Part II | Date/Time Prepared: 5/22/2024 9:54 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-352,939	1,026,020	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	513,474	6.00
7.00	Physical Therapy	0	0	0	0	0	413,879	7.00
8.00	Occupational Therapy	0	0	0	0	0	43,962	8.00
9.00	Speech Pathology	0	0	0	0	0	13,284	9.00
10.00	Medical Social Services	0	0	0	0	0	7,780	10.00
11.00	Home Health Aide	0	0	0	0	0	4,016	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	29,625	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-352,939	1,026,020	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		352,939	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.343988	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1341 | HHA CCN: 14-7299 | Period: From 01/01/2023 To 12/31/2023 | Worksheet H-2 Part I | Date/Time Prepared: 5/22/2024 9:54 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS BLDG & FIXT NEW BDG EX	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		0	1.00	1.01	2.00	4.00	5.01	
1.00	Administrative and General	0	41,316	0	25,518	50,180	1,820	1.00
2.00	Skilled Nursing Care	690,104	5,012	0	0	149,891	4,248	2.00
3.00	Physical Therapy	556,248	620	0	0	94,486	1,213	3.00
4.00	Occupational Therapy	59,084	316	0	0	7,757	607	4.00
5.00	Speech Pathology	17,854	134	0	0	3,358	0	5.00
6.00	Medical Social Services	10,456	0	0	0	2,271	0	6.00
7.00	Home Health Aide	5,397	97	0	0	1,172	0	7.00
8.00	Supplies (see instructions)	39,816	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	1,213	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,378,959	47,495	0	25,518	309,115	9,101	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	DATA PROCESSING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.02	5.03	5A.03	5.04	7.00	8.00	
1.00	Administrative and General	17,744	0	136,578	12,607	111,689	0	1.00
2.00	Skilled Nursing Care	17,744	0	866,999	80,028	13,550	0	2.00
3.00	Physical Therapy	3,549	0	656,116	60,562	1,677	0	3.00
4.00	Occupational Therapy	0	0	67,764	6,255	855	0	4.00
5.00	Speech Pathology	0	0	21,346	1,970	362	0	5.00
6.00	Medical Social Services	0	0	12,727	1,175	0	0	6.00
7.00	Home Health Aide	0	0	6,666	615	263	0	7.00
8.00	Supplies (see instructions)	0	0	39,816	3,675	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	7,098	0	8,311	767	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	46,135	0	1,816,323	167,654	128,396	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.000000				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1341 | HHA CCN: 14-7299 | Period: From 01/01/2023 To 12/31/2023 | Worksheet H-2 Part I | Date/Time Prepared: 5/22/2024 9:54 am

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	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	30,120	0	12,311	0	6,801	0	1.00
2.00	Skilled Nursing Care	4,477	0	0	0	0	0	2.00
3.00	Physical Therapy	554	0	0	0	0	0	3.00
4.00	Occupational Therapy	283	0	0	0	0	0	4.00
5.00	Speech Pathology	120	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	87	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	35,641	0	12,311	0	6,801	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		16.00	17.00	19.00	24.00	25.00	26.00	
1.00	Administrative and General	7,096	0	0	317,202	0	317,202	1.00
2.00	Skilled Nursing Care	0	0	0	965,054	0	965,054	2.00
3.00	Physical Therapy	0	0	0	718,909	0	718,909	3.00
4.00	Occupational Therapy	0	0	0	75,157	0	75,157	4.00
5.00	Speech Pathology	0	0	0	23,798	0	23,798	5.00
6.00	Medical Social Services	0	0	0	13,902	0	13,902	6.00
7.00	Home Health Aide	0	0	0	7,631	0	7,631	7.00
8.00	Supplies (see instructions)	0	0	0	43,491	0	43,491	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	9,078	0	9,078	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	7,096	0	0	2,174,222	0	2,174,222	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1341 | HHA CCN: 14-7299 | Period: From 01/01/2023 To 12/31/2023 | Worksheet H-2 Part I | Date/Time Prepared: 5/22/2024 9:54 am

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	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs			
		27.00	28.00			
1.00	Administrative and General					1.00
2.00	Skilled Nursing Care	164,843	1,129,897			2.00
3.00	Physical Therapy	122,798	841,707			3.00
4.00	Occupational Therapy	12,838	87,995			4.00
5.00	Speech Pathology	4,065	27,863			5.00
6.00	Medical Social Services	2,375	16,277			6.00
7.00	Home Health Aide	1,303	8,934			7.00
8.00	Supplies (see instructions)	7,429	50,920			8.00
9.00	Drugs	0	0			9.00
10.00	DME	0	0			10.00
11.00	Home Dialysis Aide Services	0	0			11.00
12.00	Respiratory Therapy	0	0			12.00
13.00	Private Duty Nursing	0	0			13.00
14.00	Clinic	0	0			14.00
15.00	Health Promotion Activities	0	0			15.00
16.00	Day Care Program	0	0			16.00
17.00	Home Delivered Meals Program	0	0			17.00
18.00	Homemaker Service	0	0			18.00
19.00	All Others (specify)	1,551	10,629			19.00
19.50	Telemedicine	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	317,202	2,174,222			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.170812				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1341 | HHA CCN: 14-7299 | Period: From 01/01/2023 To 12/31/2023 | Worksheet H-2 Part II | Date/Time Prepared: 5/22/2024 9:54 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	BLDG & FIXT NEW BDG EX (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (# OF PHONE S)	DATA PROCESSING (# OF TERMI NALS)	
		1.00	1.01	2.00	4.00	5.01	5.02	
1.00	Administrative and General	3,396	0	24,992	171,900	3	5	1.00
2.00	Skilled Nursing Care	412	0	0	513,474	7	5	2.00
3.00	Physical Therapy	51	0	0	323,674	2	1	3.00
4.00	Occupational Therapy	26	0	0	26,571	1	0	4.00
5.00	Speech Pathology	11	0	0	11,502	0	0	5.00
6.00	Medical Social Services	0	0	0	7,780	0	0	6.00
7.00	Home Health Aide	8	0	0	4,016	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	2	2	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	3,904	0	24,992	1,058,917	15	13	20.00
21.00	Total cost to be allocated	47,495	0	25,518	309,115	9,101	46,135	21.00
22.00	Unit cost multiplier	12.165727	0.000000	1.021047	0.291916	606.733333	3,548.846154	22.00

	Cost Center Description	CASHIERING/ACC OUNTS RECEIVABLE (GROSS REVE NUE)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5.03	5A.04	5.04	7.00	8.00	9.00	
1.00	Administrative and General	0	0	136,578	3,396	0	2,772	1.00
2.00	Skilled Nursing Care	0	0	866,999	412	0	412	2.00
3.00	Physical Therapy	0	0	656,116	51	0	51	3.00
4.00	Occupational Therapy	0	0	67,764	26	0	26	4.00
5.00	Speech Pathology	0	0	21,346	11	0	11	5.00
6.00	Medical Social Services	0	0	12,727	0	0	0	6.00
7.00	Home Health Aide	0	0	6,666	8	0	8	7.00
8.00	Supplies (see instructions)	0	0	39,816	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	8,311	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0		1,816,323	3,904	0	3,280	20.00
21.00	Total cost to be allocated	0		167,654	128,396	0	35,641	21.00
22.00	Unit cost multiplier	0.000000		0.092304	32.888320	0.000000	10.866159	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1341 HHA CCN: 14-7299

Period: From 01/01/2023 To 12/31/2023

Worksheet H-2 Part II Date/Time Prepared: 5/22/2024 9:54 am

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	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	7,654	0	3,690	0	1,475,474	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	7,654	0	3,690	0	1,475,474	20.00
21.00	Total cost to be allocated	0	12,311	0	6,801	0	7,096	21.00
22.00	Unit cost multiplier	0.000000	1.608440	0.000000	1.843089	0.000000	0.004809	22.00

	Cost Center Description	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)					
		17.00	19.00					
1.00	Administrative and General	0	0					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	0	0					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19)	0	0					20.00
21.00	Total cost to be allocated	0	0					21.00
22.00	Unit cost multiplier	0.000000	0.000000					22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1341 | HHA CCN: 14-7299 | Period: From 01/01/2023 To 12/31/2023 | Worksheet H-3 Part I | Date/Time Prepared: 5/22/2024 9:54 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,129,897		1,129,897	3,756	300.82	1.00
2.00	Physical Therapy	3.00	841,707	0	841,707	3,745	224.75	2.00
3.00	Occupational Therapy	4.00	87,995	0	87,995	722	121.88	3.00
4.00	Speech Pathology	5.00	27,863	0	27,863	74	376.53	4.00
5.00	Medical Social Services	6.00	16,277		16,277	27	602.85	5.00
6.00	Home Health Aide	7.00	8,934		8,934	19	470.21	6.00
7.00	Total (sum of lines 1-6)		2,112,673	0	2,112,673	8,343		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	1,352			8.00
8.01	Skilled Nursing Care		41180	0	214			8.01
9.00	Physical Therapy		99914	0	1,728			9.00
9.01	Physical Therapy		41180	0	304			9.01
10.00	Occupational Therapy		99914	0	283			10.00
10.01	Occupational Therapy		41180	0	118			10.01
11.00	Speech Pathology		99914	0	36			11.00
11.01	Speech Pathology		41180	0	8			11.01
12.00	Medical Social Services		99914	0	11			12.00
12.01	Medical Social Services		41180	0	5			12.01
13.00	Home Health Aide		99914	0	13			13.00
13.01	Home Health Aide		41180	0	14			13.01
14.00	Total (sum of lines 8-13)			0	4,086			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	50,920	0	50,920	49,972	1.018971	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,566		0	471,084		1.00
2.00	Physical Therapy	0	2,032		0	456,692		2.00
3.00	Occupational Therapy	0	401		0	48,874		3.00
4.00	Speech Pathology	0	44		0	16,567		4.00
5.00	Medical Social Services	0	16		0	9,646		5.00
6.00	Home Health Aide	0	27		0	12,696		6.00
7.00	Total (sum of lines 1-6)	0	4,086		0	1,015,559		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-1341 HHA CCN: 14-7299 | Period: From 01/01/2023 To 12/31/2023 | Worksheet H-3 Part I Date/Time Prepared: 5/22/2024 9:54 am

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	8,693	0	0	8,858	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)		
		12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
	Cost Per Visit Computation			
1.00	Skilled Nursing Care	471,084		1.00
2.00	Physical Therapy	456,692		2.00
3.00	Occupational Therapy	48,874		3.00
4.00	Speech Pathology	16,567		4.00
5.00	Medical Social Services	9,646		5.00
6.00	Home Health Aide	12,696		6.00
7.00	Total (sum of lines 1-6)	1,015,559		7.00

	Cost Center Description			
		12.00		
	Limitation Cost Computation			
8.00	Skilled Nursing Care			8.00
8.01	Skilled Nursing Care			8.01
9.00	Physical Therapy			9.00
9.01	Physical Therapy			9.01
10.00	Occupational Therapy			10.00
10.01	Occupational Therapy			10.01
11.00	Speech Pathology			11.00
11.01	Speech Pathology			11.01
12.00	Medical Social Services			12.00
12.01	Medical Social Services			12.01
13.00	Home Health Aide			13.00
13.01	Home Health Aide			13.01
14.00	Total (sum of lines 8-13)			14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1341
HHA CCN: 14-7299

Period:
From 01/01/2023
To 12/31/2023

Worksheet H-3
Part II
Date/Time Prepared:
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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.460198	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.136902	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.301007	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1341 | HHA CCN: 14-7299 | Period: From 01/01/2023 To 12/31/2023 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/22/2024 9:54 am

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	778,900	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	66,020	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	10,551	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	1,617	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	13,346	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	403	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	870,837	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	870,837	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	870,837	26.00
27.00	Allowable bad debts (from your records)		0	27.00
27.01	Adjusted reimbursable bad debts (see instructions)		0	27.01
28.00	Allowable bad debts for dual eligible (see instructions)		0	28.00
29.00	Total costs - current cost reporting period (see instructions)	0	870,837	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	870,837	31.00
31.01	Sequestration adjustment (see instructions)	0	17,416	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
31.75	Sequestration adjustment for non-claims based amounts (see instructions)	0	0	31.75
32.00	Interim payments (see instructions)	0	853,421	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-1341 | HHA CCN: 14-7299 | Period: From 01/01/2023 To 12/31/2023 | Worksheet H-5 | Date/Time Prepared: 5/22/2024 9:54 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		853,421	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			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		853,421	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		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		853,421	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-1341 | Hospice CCN: 14-1575 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O | Date/Time Prepared: 5/22/2024 9:54 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	82,354	100,968	183,322	0	183,322	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	4,442	4,442	0	4,442	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	8,246	0	8,246	0	8,246	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	114,530	0	114,530	0	114,530	28.00
29.00	LPN/LVN**	33,559	0	33,559	0	33,559	29.00
30.00	PHYSICAL THERAPY**	273	0	273	0	273	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	47,752	0	47,752	0	47,752	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	59,103	0	59,103	0	59,103	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	58,329	58,329	0	58,329	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	22,955	22,955	0	22,955	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	3,748	3,748	0	3,748	71.00
100.00	TOTAL	345,817	190,442	536,259	0	536,259	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-1341 | Hospice CCN: 14-1575 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O | Date/Time Prepared: 5/22/2024 9:54 am

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	183,322		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	4,442		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	1,878	1,878		25.00
26.00	PHYSICIAN SERVICES**	0	8,246		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	114,530		28.00
29.00	LPN/LVN**	0	33,559		29.00
30.00	PHYSICAL THERAPY**	0	273		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	47,752		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	59,103		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	58,329		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	22,955		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	3,748		71.00
100.00	TOTAL	1,878	538,137		100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE CONTINUOUS HOME CARE

Provider CCN: 14-1341 | Hospice CCN: 14-1575 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-1 | Date/Time Prepared: 5/22/2024 9:54 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	0	0	0	0	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	0	0	0	0	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 50.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	0		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	0		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 50.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 14-1341 Hospice CCN: 14-1575

Period: From 01/01/2023 To 12/31/2023

Worksheet O-2 Date/Time Prepared: 5/22/2024 9:54 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	8,230	0	8,230	0	8,230	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	114,311	0	114,311	0	114,311	28.00
29.00	LPN/LVN	33,495	0	33,495	0	33,495	29.00
30.00	PHYSICAL THERAPY	272	0	272	0	272	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	47,661	0	47,661	0	47,661	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	58,990	0	58,990	0	58,990	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	58,217	58,217	0	58,217	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	22,911	22,911	0	22,911	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	262,959	81,128	344,087	0	344,087	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	8,230		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	114,311		28.00
29.00	LPN/LVN	0	33,495		29.00
30.00	PHYSICAL THERAPY	0	272		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	47,661		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	58,990		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	58,217		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	22,911		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	344,087		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE

Provider CCN: 14-1341 | Hospice CCN: 14-1575 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-3 | Date/Time Prepared: 5/22/2024 9:54 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	16	0	16	0	16	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	219	0	219	0	219	28.00
29.00	LPN/LVN	64	0	64	0	64	29.00
30.00	PHYSICAL THERAPY	1	0	1	0	1	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	91	0	91	0	91	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	113	0	113	0	113	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	112	112	0	112	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	44	44	0	44	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	504	156	660	0	660	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	1,878	1,878		25.00
26.00	PHYSICIAN SERVICES	0	16		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	219		28.00
29.00	LPN/LVN	0	64		29.00
30.00	PHYSICAL THERAPY	0	1		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	91		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	113		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	112		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	44		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	1,878	2,538		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 14-1341 Hospice CCN: 14-1575

Period: From 01/01/2023 To 12/31/2023

Worksheet O-5

Date/Time Prepared: 5/22/2024 9:54 am

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,990	6,990	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	100,950	100,950	3.00
4.00	ADMINISTRATIVE & GENERAL	183,322	148,263	331,585	4.00
5.00	PLANT OPERATION & MAINTENANCE	4,442	0	4,442	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	273	273	10.00
11.00	MEDICAL RECORDS	0	4,079	4,079	11.00
12.00	STAFF TRANSPORTATION	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	344,087		344,087	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2,538		2,538	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0		0	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	3,748		3,748	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	538,137	260,555	798,692	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-1341
Hospice CCN: 14-1575

Period: From 01/01/2023 To 12/31/2023

Worksheet O-6 Part I
Date/Time Prepared: 5/22/2024 9:54 am

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,990		6,990			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	100,950	0	0	100,950		3.00
4.00	ADMINISTRATIVE & GENERAL	331,585	0	6,990	24,041	362,616	4.00
5.00	PLANT OPERATION & MAINTENANCE	4,442	0	0	0	4,442	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	273	0	0	0	273	10.00
11.00	MEDICAL RECORDS	4,079	0	0	0	4,079	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	344,087			76,909	420,996	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2,538	0	0	0	2,538	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	3,748	0	0	0	3,748	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	798,692	0	6,990	100,950	798,692	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-1341
Hospice CCN: 14-1575

Period: From 01/01/2023 To 12/31/2023

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	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	362,616					4.00
5.00	PLANT OPERATION & MAINTENANCE	3,694	8,136				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	227	0		0		10.00
11.00	MEDICAL RECORDS	3,392	0		0		11.00
12.00	STAFF TRANSPORTATION	0	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	0	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	350,076					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2,110	8,136	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	3,117	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	362,616	8,136	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-1341
Hospice CCN: 14-1575

Period: From 01/01/2023 To 12/31/2023

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	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	500				10.00
11.00	MEDICAL RECORDS	0		7,471			11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	499	7,457	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	1	14	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	500	7,471	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-1341
Hospice CCN: 14-1575

Period:
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	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0		779,028	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	12,799	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	6,865	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	0	0	798,692	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-1341
Hospice CCN: 14-1575

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	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		6,846				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	345,817			3.00
4.00	ADMINISTRATIVE & GENERAL	0	6,846	82,354	-362,616	436,076	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	4,442	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	273	10.00
11.00	MEDICAL RECORDS	0	0	0	0	4,079	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			263,463	0	420,996	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	2,538	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	3,748	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	6,990	100,950		362,616	100.00
101.00	UNIT COST MULTIPLIER	0.000000	1.021034	0.291917		0.831543	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-1341
Hospice CCN: 14-1575

Period:
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	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	5,933					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	5,933	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	8,136	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	1.371313	0.000000	0.000000	0.000000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-1341
Hospice CCN: 14-1575

Period:
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	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	4,702					10.00
11.00	MEDICAL RECORDS		4,702				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	4,693	4,693	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	9	9	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	500	7,471	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.106338	1.588898	0.000000	0.000000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-1341
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	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 14-1341 Hospice CCN: 14-1575

Period: From 01/01/2023 To 12/31/2023

Worksheet O-7

Date/Time Prepared: 5/22/2024 9:54 am

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.460198	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.301007	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.173627	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.136902	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-1341 | Hospice CCN: 14-1575 | Period: From 01/01/2023 To 12/31/2023 | Worksheet O-8 | Date/Time Prepared: 5/22/2024 9:54 am

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			779,028	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			4,693	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			166.00	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	4,440	102		9.00
10.00	Program cost (line 8 times line 9)	737,040	16,932		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			12,799	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			9	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			1,422.11	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	9	0		14.00
15.00	Program cost (line 13 times line 14)	12,799	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			0	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			0	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			0.00	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	0	0		19.00
20.00	Program cost (line 18 times line 19)	0	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			791,827	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			4,702	22.00
23.00	Average cost per diem (line 21 divided by line 22)			168.40	23.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1341 | Component CCN: 14-8508 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/22/2024 9:54 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	735,798	0	735,798	-26,553	709,245	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	603,575	0	603,575	-3,966	599,609	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	425,382	0	425,382	-2,261	423,121	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	25,359	25,359	0	25,359	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	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,764,755	25,359	1,790,114	-32,780	1,757,334	10.00
11.00	Physician Services Under Agreement	0	207,815	207,815	57,560	265,375	11.00
12.00	Physician Supervision Under Agreement	27,697	0	27,697	0	27,697	12.00
13.00	Other Costs Under Agreement	0	5	5	0	5	13.00
14.00	Subtotal (sum of lines 11 through 13)	27,697	207,820	235,517	57,560	293,077	14.00
15.00	Medical Supplies	0	178,587	178,587	0	178,587	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	29,187	29,187	0	29,187	18.00
19.00	Other Health Care Costs	0	1,118	1,118	0	1,118	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	208,892	208,892	0	208,892	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,792,452	442,071	2,234,523	24,780	2,259,303	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	32,780	32,780	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	3,113	3,113	-57,560	-54,447	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	3,113	3,113	-24,780	-21,667	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	4,687	4,687	-2,475	2,212	29.00
30.00	Administrative Costs	329,328	224,428	553,756	2,266	556,022	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	329,328	229,115	558,443	-209	558,234	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,121,780	674,299	2,796,079	-209	2,795,870	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1341 | Component CCN: 14-8508 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/22/2024 9:54 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-25,695	683,550		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	599,609		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	423,121		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	25,359		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	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-25,695	1,731,639		10.00
11.00	Physician Services Under Agreement	0	265,375		11.00
12.00	Physician Supervision Under Agreement	0	27,697		12.00
13.00	Other Costs Under Agreement	0	5		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	293,077		14.00
15.00	Medical Supplies	0	178,587		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	29,187		18.00
19.00	Other Health Care Costs	0	1,118		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	208,892		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-25,695	2,233,608		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	32,780		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	-54,447		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	-21,667		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	2,212		29.00
30.00	Administrative Costs	0	556,022		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	558,234		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-25,695	2,770,175		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1341 | Component CCN: 14-8633 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/22/2024 9:54 am

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	326,947	0	326,947	-7,215	319,732	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	177,771	0	177,771	-7,042	170,729	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	276,960	0	276,960	0	276,960	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
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	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	781,678	0	781,678	-14,257	767,421	10.00
11.00	Physician Services Under Agreement	0	265,614	265,614	0	265,614	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	265,614	265,614	0	265,614	14.00
15.00	Medical Supplies	0	88,027	88,027	0	88,027	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	19,665	19,665	0	19,665	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	107,692	107,692	0	107,692	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	781,678	373,306	1,154,984	-14,257	1,140,727	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	14,257	14,257	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	14,257	14,257	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	14,446	14,446	0	14,446	29.00
30.00	Administrative Costs	240,596	112,108	352,704	0	352,704	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	240,596	126,554	367,150	0	367,150	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,022,274	499,860	1,522,134	0	1,522,134	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1341 | Component CCN: 14-8633 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/22/2024 9:54 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	319,732		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	170,729		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	276,960		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		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	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	767,421		10.00
11.00	Physician Services Under Agreement	0	265,614		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	265,614		14.00
15.00	Medical Supplies	0	88,027		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	19,665		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	107,692		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,140,727		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	14,257		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	14,257		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	14,446		29.00
30.00	Administrative Costs	0	352,704		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	367,150		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,522,134		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1341 | Component CCN: 14-8637 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/22/2024 9:54 am

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	4,352	0	4,352	0	4,352	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	208,759	0	208,759	-58,567	150,192	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	80,322	0	80,322	0	80,322	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
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	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	293,433	0	293,433	-58,567	234,866	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	9,294	9,294	0	9,294	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	3,103	3,103	0	3,103	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	12,397	12,397	0	12,397	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	293,433	12,397	305,830	-58,567	247,263	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	58,567	58,567	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	58,567	58,567	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	1,897	1,897	0	1,897	29.00
30.00	Administrative Costs	68,644	39,857	108,501	0	108,501	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	68,644	41,754	110,398	0	110,398	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	362,077	54,151	416,228	0	416,228	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1341 | Component CCN: 14-8637 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/22/2024 9:54 am

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	4,352		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	150,192		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	80,322		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		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	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	234,866		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	9,294		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	3,103		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	12,397		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	247,263		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	58,567		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	58,567		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	1,897		29.00
30.00	Administrative Costs	0	108,501		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	110,398		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	416,228		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1341 | Component CCN: 14-8508 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/22/2024 9:54 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.01	6,983	4,200	8,442		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	3.65	8,851	2,100	7,665		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.66	15,834		16,107	16,107	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.10	217			217	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)	5.76	16,051			16,324	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,233,608	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					-21,667	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,211,941	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.009795	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					558,234	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,457,262	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,015,496	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,015,496	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,035,238	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,268,846	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1341 | Component CCN: 14-8633 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/22/2024 9:54 am

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.31	4,274	4,200	5,502		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.24	2,683	2,100	2,604		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.55	6,957		8,106	8,106	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
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)	2.55	6,957			8,106	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)	1,140,727	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	14,257	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,154,984	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.987656	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	367,150	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	734,871	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,102,021	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,102,021	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,088,418	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,229,145	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1341 | Component CCN: 14-8637 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/22/2024 9:54 am

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.04	155	4,200	168		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.08	3,304	2,100	2,268		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.12	3,459		2,436	3,459	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
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)	1.12	3,459			3,459	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)	247,263	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	58,567	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	305,830	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.808498	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	110,398	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	258,674	15.00
16.00	Total overhead (sum of lines 14 and 15)	369,072	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	369,072	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	298,394	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	545,657	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1341 Component CCN: 14-8508	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/22/2024 9:54 am
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		4,268,846	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		61,070	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		4,207,776	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		16,324	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)		16,324	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		257.77	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	271.90	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	257.77	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,750	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	708,868	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	9	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	2,320	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	2,320	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	711,188	16.00
16.01	Total program charges (see instructions)(from contractor's records)		638,853	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		46,756	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		52,050	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.)		473,279	16.04
16.05	Total program cost (see instructions)	0	525,329	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		67,539	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		104,064	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		525,329	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		13,747	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 coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		539,076	22.00
23.00	Allowable bad debts (see instructions)		8,887	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		5,777	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		8,887	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)		544,853	26.00
26.01	Sequestration adjustment (see instructions)		10,897	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		441,064	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)		92,892	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1341 Component CCN: 14-8633	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/22/2024 9:54 am
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,229,145	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			29,100	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,200,045	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,106	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)			8,106	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			271.41	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	999.00		8.00
9.00	Rate for Program covered visits (see instructions)	0.00	271.41		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,836		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	498,309		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	498,309		16.00
16.01	Total program charges (see instructions)(from contractor's records)		322,289		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		45,361		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		70,135		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.)		321,194		16.04
16.05	Total program cost (see instructions)	0	391,329		16.05
17.00	Primary payer amounts		107		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		26,682		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		49,644		19.00
20.00	Net program cost excluding injections/infusions (see instructions)		391,222		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		13,092		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 coinsurance (see instructions)				21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		404,314		22.00
23.00	Allowable bad debts (see instructions)		2,654		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		1,725		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		2,654		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)		406,039		26.00
26.01	Sequestration adjustment (see instructions)		8,121		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		149,127		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)		248,791		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1341 Component CCN: 14-8637	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/22/2024 9:54 am
	Title XVIII	RHC III	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		545,657	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		2,548	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		543,109	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,459	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)		3,459	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		157.01	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	126.00	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	126.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	416	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	52,416	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	52,416	16.00
16.01	Total program charges (see instructions)(from contractor's records)		55,994	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		486	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		455	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.)		36,865	16.04
16.05	Total program cost (see instructions)	0	37,320	16.05
17.00	Primary payer amounts		29	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		5,880	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		9,926	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		37,291	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,052	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 coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		38,343	22.00
23.00	Allowable bad debts (see instructions)		1,042	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		677	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,042	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)		39,020	26.00
26.01	Sequestration adjustment (see instructions)		780	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		30,437	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)		7,803	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: 14-1341 | Component CCN: 14-8508 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/22/2024 9:54 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,731,639	1,731,639	1,731,639	1,731,639	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000185	0.000469	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	320	812	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	21,285	9,537	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	21,605	10,349	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,233,608	2,233,608	2,233,608	2,233,608	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,035,238	2,035,238	2,035,238	2,035,238	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.009673	0.004633	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	19,687	9,429	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	41,292	19,778	0	0	10.00
11.00	Total number of injections/infusions (from your records)	108	274	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	382.33	72.18	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	15	111	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	5,735	8,012	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		61,070	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)		13,747	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1341 | Component CCN: 14-8633 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/22/2024 9:54 am

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	767,421	767,421	767,421	767,421	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000121	0.000409	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	93	314	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	8,547	5,937	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	8,640	6,251	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,140,727	1,140,727	1,140,727	1,140,727	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,088,418	1,088,418	1,088,418	1,088,418	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.007574	0.005480	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	8,244	5,965	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	16,884	12,216	0	0	10.00
11.00	Total number of injections/infusions (from your records)	46	156	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	367.04	78.31	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	25	50	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	9,176	3,916	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		29,100	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)		13,092	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1341 | Component CCN: 14-8637 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/22/2024 9:54 am

Title XVIII | RHC III | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	234,866	234,866	234,866	234,866	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000027	0.000184	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	6	43	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	654	452	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	660	495	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	247,263	247,263	247,263	247,263	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	298,394	298,394	298,394	298,394	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.002669	0.002002	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	796	597	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1,456	1,092	0	0	10.00
11.00	Total number of injections/infusions (from your records)	4	27	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	364.00	40.44	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	2	8	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	728	324	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		2,548	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)		1,052	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1341 Component CCN: 14-8508	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/22/2024 9:54 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		427,937	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		07/19/2023	13,127	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		13,127	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		441,064	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		92,892	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		533,956	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1341 Component CCN: 14-8633	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/22/2024 9:54 am
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		95,304	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		07/19/2023	53,823	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		53,823	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		149,127	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		248,791	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		397,918	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1341 Component CCN: 14-8637	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/22/2024 9:54 am
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		23,694	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		07/19/2023	6,743	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		6,743	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		30,437	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		7,803	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		38,240	7.00

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