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: 14-1327	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/17/2024 11:02 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/17/2024 Time: 11:02 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 WABASH GENERAL HOSPITAL DISTRICT (14-1327) 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	Karissa Turner		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	Karissa Turner			2
3	Signatory Title	CEO			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	823,141	-1,742,670	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	171,204	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		16,769		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-24,909		0	10.01
10.02	RURAL HEALTH CLINIC III	0		81,142		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		53,784		0	10.03
10.04	RURAL HEALTH CLINIC V	0		158,335		0	10.04
10.05	RURAL HEALTH CLINIC VI	0		46,445		0	10.05
200.00	TOTAL	0	994,345	-1,411,104	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/17/2024 11:02 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1418 COLLEGE DRIVE	PO Box:			1.00
2.00	City: MT. CARMEL	State: IL	Zip Code: 62863	County: WABASH	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	WABASH GENERAL HOSPITAL DISTRICT	141327	99914	1	06/01/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	WABASH GENERAL HOSPITAL SWING BEDS	14Z327	99914		06/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	WABASH GENERAL RHC	148501	99914		04/13/2009	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	WABASH PRIMARY CARE	148568	99914		08/09/2016	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	WABASH PRIMARY CARE - COLLEGE DR	148579	99914		10/01/2017	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	WABASH PRIMARY CARE - OAK STREET	148599	99914		07/01/2019	N	O	N	15.03
15.04	Hospital-Based Health Clinic - RHC V	WABASH PRIMARY CARE - ALBION	148601	99914		08/09/2019	N	O	N	15.04
15.05	Hospital-Based Health Clinic - RHC VI	WABASH GENERAL HOSPITAL - GRAYVILLE	148613	99914		07/27/2020	N	O	N	15.05
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)	11		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/17/2024 11:02 am

		1.00	2.00	3.00	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/17/2024 11:02 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/17/2024 11:02 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/17/2024 11:02 am

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/17/2024 11:02 am

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/17/2024 11:02 am

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/17/2024 11:02 am

		1.00	2.00	
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1327	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/17/2024 11:02 am

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/17/2024 11:02 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	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/03/2024	Y	04/03/2024	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/17/2024 11:02 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SHAWN		ADAMS		41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923508		SADAMS@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1327	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/17/2024 11:02 am

		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.	MANAGER		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: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 5/17/2024 11:02 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	25	9,125	38,448.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	38,448.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	38,448.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
26.04	RURAL HEALTH CLINIC V	88.04				0	26.04
26.05	RURAL HEALTH CLINIC VI	88.05				0	26.05
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/17/2024 11:02 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,147	5	1,602			1.00
2.00	HMO and other (see instructions)	187	65				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	448	0	448			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	137			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,595	5	2,187			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)	1,595	5	2,187	0.00	405.94	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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	459	0	3,376	0.00	1.34	26.00
26.01	RURAL HEALTH CLINIC II	1,539	0	11,512	0.00	21.70	26.01
26.02	RURAL HEALTH CLINIC III	3,878	0	5,981	0.00	8.44	26.02
26.03	RURAL HEALTH CLINIC IV	2,941	0	7,289	0.00	9.31	26.03
26.04	RURAL HEALTH CLINIC V	2,621	0	4,532	0.00	9.81	26.04
26.05	RURAL HEALTH CLINIC VI	1,423	0	3,749	0.00	8.01	26.05
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	464.55	27.00
28.00	Observation Bed Days		0	205			28.00
29.00	Ambulance Trips	747					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/17/2024 11:02 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	325	1	480	1.00
2.00	HMO and other (see instructions)			45	19		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	325	1	480	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
26.04	RURAL HEALTH CLINIC V	0.00					26.04
26.05	RURAL HEALTH CLINIC VI	0.00					26.05
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1327 | Component CCN: 14-8501 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/17/2024 11:02 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1418 COLLEGE DRIVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MT.CARMEL		IL	62863	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
9.01						9.01
9.02						9.02
9.03						9.03
9.04						9.04
9.05						9.05
9.06						9.06
9.07						9.07
9.08						9.08
9.09						9.09
9.10						9.10
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC	10:00	22:00	15:00	21:00	15:00	11.00

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1327 | Component CCN: 14-8501 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/17/2024 11:02 am

RHC I | Cost

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

		County					
		4.00					
2.00	City, State, ZIP Code, County	WABASH					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	21:00	18:00	21:00	18:00	21:00	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	15:00	21:00	10:00	22:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1327 | Component CCN: 14-8568 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/17/2024 11:02 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1123 CHESTNUT STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MOUNT CARMEL		IL	62863-1212	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

	1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y	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: 14-1327 Component CCN: 14-8568	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/17/2024 11:02 am
		RHC II	Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		WABASH				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	18:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1327 | Component CCN: 14-8579 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/17/2024 11:02 am

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1418 COLLEGE DR		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MOUNT CARMEL		IL	62863	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
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: 14-1327 | Component CCN: 14-8579 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/17/2024 11:02 am

RHC III | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		WABASH				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1327 | Component CCN: 14-8599 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/17/2024 11:02 am

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1106 OAK STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MOUNT CARMEL		IL	62863	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
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: 14-1327 | Component CCN: 14-8599 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/17/2024 11:02 am

RHC IV | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		WABASH				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1327 | Component CCN: 14-8601 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/17/2024 11:02 am

RHC V | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			26 EAST ELM STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ALBION		IL	62806	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
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: 14-1327 | Component CCN: 14-8601 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/17/2024 11:02 am

RHC V | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		EDWARDS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	09:00	18:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	16:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1327 | Component CCN: 14-8613 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/17/2024 11:02 am

RHC VI | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			610 N COURT ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	GRAYVILLE		IL	62844	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	10:00	22:00	15:00	21:00	15:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00
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: 14-1327
Component CCN: 14-8613

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

Worksheet S-8

Date/Time Prepared:
5/17/2024 11:02 am

RHC VI

Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		EDWARDS				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	21:00	18:00	21:00	18:00	21:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	15:00	21:00	10:00	22:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/17/2024 11:02 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)	0.381424	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	13,542,391	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	32,335,352	6.00
7.00	Medicaid cost (line 1 times line 6)	12,333,479	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	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)	174,052	0	174,052	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	66,388	0	66,388	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	66,388	0	66,388	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)	8,039,625	26.00
27.00	Medicare reimbursable bad debts (see instructions)	544,123	27.00
27.01	Medicare allowable bad debts (see instructions)	837,111	27.01
28.00	Non-Medicare bad debt amount (see instructions)	7,202,514	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	3,040,200	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	3,106,588	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,106,588	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/17/2024 11:02 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: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/17/2024 11:02 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	NEW CAP REL COSTS-BLDG & FIXT		1,871,139	1,871,139	-347,218	1,523,921	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2,979,541	2,979,541	127,935	3,107,476	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	438,968	1,216,965	1,655,933	0	1,655,933	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,693,227	7,680,559	11,373,786	-370,911	11,002,875	5.00
7.00	00700	OPERATION OF PLANT	373,405	1,984,520	2,357,925	120,618	2,478,543	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	139,102	139,102	8.00
9.00	00900	HOUSEKEEPING	531,816	289,034	820,850	0	820,850	9.00
10.00	01000	DIETARY	553,433	538,133	1,091,566	-934,760	156,806	10.00
11.00	01100	CAFETERIA	0	0	0	920,160	920,160	11.00
13.00	01300	NURSING ADMINISTRATION	611,577	127,307	738,884	0	738,884	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	498,439	1,140,951	1,639,390	-2,057	1,637,333	16.00
17.00	01700	SOCIAL SERVICE	205,690	67,920	273,610	0	273,610	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,373,373	321,139	1,694,512	-14,796	1,679,716	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,032,205	1,605,548	3,637,753	-36,292	3,601,461	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,498,779	5,800,072	7,298,851	-4,339,795	2,959,056	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,080,356	1,479,617	2,559,973	-3,464	2,556,509	54.00
60.00	06000	LABORATORY	1,176,932	1,934,266	3,111,198	-14,524	3,096,674	60.00
65.00	06500	RESPIRATORY THERAPY	547,106	188,447	735,553	-19,674	715,879	65.00
65.01	06501	CARDIAC REHAB	154,301	53,307	207,608	0	207,608	65.01
65.02	06502	PULMONARY	78,312	130,923	209,235	0	209,235	65.02
65.03	06503	SLEEP STUDY	258,521	111,224	369,745	0	369,745	65.03
66.00	06600	PHYSICAL THERAPY	1,742,256	793,200	2,535,456	-18,728	2,516,728	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	275,037	275,712	550,749	773,902	1,324,651	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	3,503,508	3,503,508	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	532,758	5,903,220	6,435,978	-3,381	6,432,597	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	105,063	149,335	254,398	55,880	310,278	88.00
88.01	08802	RURAL HEALTH CLINIC II	2,346,560	459,812	2,806,372	27,140	2,833,512	88.01
88.02	08801	RURAL HEALTH CLINIC III	1,005,896	230,301	1,236,197	-7,833	1,228,364	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,095,580	276,802	1,372,382	-1,081	1,371,301	88.03
88.04	08804	RURAL HEALTH CLINIC V	718,051	346,004	1,064,055	36,290	1,100,345	88.04
88.05	08805	RURAL HEALTH CLINIC VI	574,417	275,777	850,194	23,151	873,345	88.05
90.00	09000	CLINIC	618,900	562,399	1,181,299	6,391	1,187,690	90.00
90.01	09001	ORTHOPAEDIC CLINIC	5,626,170	1,049,276	6,675,446	222,198	6,897,644	90.01
90.02	09002	SURGICAL CLINIC	936,806	533,534	1,470,340	-10,321	1,460,019	90.02
90.03	09003	CARDIOLOGY CLINIC	826,912	78,780	905,692	7,169	912,861	90.03
90.04	09004	SENIOR CARE CLINIC	159,141	150,911	310,052	10,264	320,316	90.04
90.05	09005	SPECIALTY CLINIC	156,114	558,661	714,775	82,772	797,547	90.05
91.00	09100	EMERGENCY	1,847,629	2,216,203	4,063,832	-10,637	4,053,195	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,478,488	611,767	2,090,255	95,151	2,185,406	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,152,218	43,992,306	79,144,524	16,159	79,160,683	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OUTREACH	214,483	88,000	302,483	-33,100	269,383	192.01
192.02	19202	CLINIC	757,944	212,789	970,733	16,941	987,674	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	36,124,645	44,293,095	80,417,740	0	80,417,740	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/17/2024 11:02 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	1,523,921		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-446,887	2,660,589		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-202,452	1,453,481		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-697,709	10,305,166		5.00
7.00	00700	OPERATION OF PLANT	0	2,478,543		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	139,102		8.00
9.00	00900	HOUSEKEEPING	0	820,850		9.00
10.00	01000	DIETARY	-15,404	141,402		10.00
11.00	01100	CAFETERIA	-239,349	680,811		11.00
13.00	01300	NURSING ADMINISTRATION	0	738,884		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-13,028	1,624,305		16.00
17.00	01700	SOCIAL SERVICE	0	273,610		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-1,373,373	306,343		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-967,604	2,633,857		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,959,056		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,556,509		54.00
60.00	06000	LABORATORY	0	3,096,674		60.00
65.00	06500	RESPIRATORY THERAPY	-77,072	638,807		65.00
65.01	06501	CARDIAC REHAB	0	207,608		65.01
65.02	06502	PULMONARY	0	209,235		65.02
65.03	06503	SLEEP STUDY	-41,490	328,255		65.03
66.00	06600	PHYSICAL THERAPY	0	2,516,728		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,764	1,322,887		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,503,508		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,432,597		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	310,278		88.00
88.01	08802	RURAL HEALTH CLINIC II	0	2,833,512		88.01
88.02	08801	RURAL HEALTH CLINIC III	0	1,228,364		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	1,371,301		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,100,345		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	873,345		88.05
90.00	09000	CLINIC	0	1,187,690		90.00
90.01	09001	ORTHOPAEDIC CLINIC	-3,510,362	3,387,282		90.01
90.02	09002	SURGICAL CLINIC	-744,320	715,699		90.02
90.03	09003	CARDIOLOGY CLINIC	-765,657	147,204		90.03
90.04	09004	SENIOR CARE CLINIC	0	320,316		90.04
90.05	09005	SPECIALTY CLINIC	0	797,547		90.05
91.00	09100	EMERGENCY	-722,982	3,330,213		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	2,185,406		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,819,453	69,341,230		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	OUTREACH	0	269,383		192.01
192.02	19202	CLINIC	0	987,674		192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,819,453	70,598,287		200.00

RECLASSIFICATIONS | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/17/2024 11:02 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RENT					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	180,107		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
	TOTALS		0	180,107		
	B - CAFE					
1.00	CAFETERIA	11.00	472,853	447,307		1.00
	TOTALS		472,853	447,307		
	D - OXYGEN					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16,517		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	16,517		
	E - UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	169,334		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
	TOTALS		0	169,334		
	F - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	3,503,508		1.00
	TOTALS		0	3,503,508		
	G - LINEN					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	139,102		1.00
	TOTALS		0	139,102		
	H - INSURANCE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	241,000		1.00
	TOTALS		0	241,000		
	I - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	897,549		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
	TOTALS		0	897,549		

RECLASSIFICATIONS | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/17/2024 11:02 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	J - SPEIR RECLASS					
1.00	RURAL HEALTH CLINIC II	88.01	1,439	0		1.00
	TOTALS		1,439	0		
	K - KINSOLVING RECLASS					
1.00	RURAL HEALTH CLINIC	88.00	54,825	0		1.00
	TOTALS		54,825	0		
	L - DEPRECIATION RECLASS B&F					
1.00	RURAL HEALTH CLINIC II	88.01	0	25,445		1.00
2.00	RURAL HEALTH CLINIC IV	88.03	0	45,976		2.00
3.00	RURAL HEALTH CLINIC V	88.04	0	16,743		3.00
4.00	RURAL HEALTH CLINIC VI	88.05	0	18,618		4.00
5.00	ORTHOPAEDIC CLINIC	90.01	0	196,695		5.00
6.00	AMBULANCE SERVICES	95.00	0	39,999		6.00
7.00	OUTREACH	192.01	0	3,742		7.00
	TOTALS		0	347,218		
	M - DEPREICATION RECLASS MME					
1.00	RURAL HEALTH CLINIC	88.00	0	1,055		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	4,148		2.00
3.00	RURAL HEALTH CLINIC IV	88.03	0	15,449		3.00
4.00	RURAL HEALTH CLINIC V	88.04	0	37,361		4.00
5.00	RURAL HEALTH CLINIC VI	88.05	0	16,468		5.00
6.00	CLINIC	90.00	0	7,857		6.00
7.00	ORTHOPAEDIC CLINIC	90.01	0	29,010		7.00
8.00	CARDIOLOGY CLINIC	90.03	0	7,169		8.00
9.00	SENIOR CARE CLINIC	90.04	0	10,264		9.00
10.00	SPECIALTY CLINIC	90.05	0	84,120		10.00
11.00	AMBULANCE SERVICES	95.00	0	58,443		11.00
12.00	OUTREACH	192.01	0	4,887		12.00
13.00	CLINIC	192.02	0	16,941		13.00
	TOTALS		0	293,172		
500.00	Grand Total: Increases		529,117	6,234,814		500.00

RECLASSIFICATIONS | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/17/2024 11:02 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,288	10		1.00
2.00	OPERATION OF PLANT	7.00	0	48,716	0		2.00
3.00	DIETARY	10.00	0	14,600	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,057	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	2,068	0		5.00
6.00	OPERATING ROOM	50.00	0	15,233	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,338	0		7.00
8.00	LABORATORY	60.00	0	14,261	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	1,502	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	11,517	0		10.00
11.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,062	0		11.00
12.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,062	0		12.00
13.00	RURAL HEALTH CLINIC II	88.01	0	2,692	0		13.00
14.00	RURAL HEALTH CLINIC III	88.02	0	1,833	0		14.00
15.00	RURAL HEALTH CLINIC IV	88.03	0	112	0		15.00
16.00	RURAL HEALTH CLINIC V	88.04	0	3,050	0		16.00
17.00	RURAL HEALTH CLINIC VI	88.05	0	1,381	0		17.00
18.00	CLINIC	90.00	0	1,466	0		18.00
19.00	ORTHOPAEDIC CLINIC	90.01	0	2,068	0		19.00
20.00	SURGICAL CLINIC	90.02	0	1,234	0		20.00
21.00	SPECIALTY CLINIC	90.05	0	1,348	0		21.00
22.00	EMERGENCY	91.00	0	2,068	0		22.00
23.00	AMBULANCE SERVICES	95.00	0	1,350	0		23.00
24.00	OUTREACH	192.01	0	38,801	0		24.00
	TOTALS		0	180,107			
	B - CAFE						
1.00	DIETARY	10.00	472,853	447,307	0		1.00
	TOTALS		472,853	447,307			
	D - OXYGEN						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	29	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	15,288	0		2.00
3.00	AMBULANCE SERVICES	95.00	0	1,200	0		3.00
	TOTALS		0	16,517			
	E - UTILITIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	120,623	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	1,200	0		2.00
3.00	RURAL HEALTH CLINIC III	88.02	0	6,000	0		3.00
4.00	RURAL HEALTH CLINIC IV	88.03	0	7,569	0		4.00
5.00	RURAL HEALTH CLINIC V	88.04	0	14,764	0		5.00
6.00	RURAL HEALTH CLINIC VI	88.05	0	10,554	0		6.00
7.00	SURGICAL CLINIC	90.02	0	5,696	0		7.00
8.00	OUTREACH	192.01	0	2,928	0		8.00
	TOTALS		0	169,334			
	F - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	3,503,508	0		1.00
	TOTALS		0	3,503,508			
	G - LINEN						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	139,102	0		1.00
	TOTALS		0	139,102			
	H - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	241,000	9		1.00
	TOTALS		0	241,000			
	I - MEDICAL SUPPLIES						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	14,796	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	34,224	0		2.00
3.00	OPERATING ROOM	50.00	0	821,054	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,097	0		4.00
5.00	LABORATORY	60.00	0	263	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	2,884	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	7,211	0		7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,319	0		8.00
9.00	SURGICAL CLINIC	90.02	0	3,391	0		9.00
10.00	EMERGENCY	91.00	0	8,569	0		10.00
11.00	AMBULANCE SERVICES	95.00	0	741	0		11.00
	TOTALS		0	897,549			
	J - SPEIR RECLASS						
1.00	ORTHOPAEDIC CLINIC	90.01	1,439	0	0		1.00
	TOTALS		1,439	0			

RECLASSIFICATIONS | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/17/2024 11:02 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	K - KINSOLVING RECLASS						
1.00	RURAL HEALTH CLINIC IV	88.03	54,825	0	0		1.00
	TOTALS		54,825	0			
	L - DEPRECIATION RECLASS B&F						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	347,218	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	TOTALS		0	347,218			
	M - DEPREICATION RECLASS MME						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	293,172	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
	TOTALS		0	293,172			
500.00	Grand Total: Decreases		529,117	6,234,814			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/17/2024 11:02 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	562,537	410,215	0	410,215	0	1.00
2.00	Land Improvements	2,512,043	15,705	0	15,705	0	2.00
3.00	Buildings and Fixtures	44,996,206	1,217,798	0	1,217,798	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	4,326,847	46,364	0	46,364	0	5.00
6.00	Movable Equipment	15,113,526	954,649	0	954,649	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	67,511,159	2,644,731	0	2,644,731	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	67,511,159	2,644,731	0	2,644,731	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	972,752	0	1.00
2.00	Land Improvements	2,527,748	0	2.00
3.00	Buildings and Fixtures	46,214,004	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	4,373,211	0	5.00
6.00	Movable Equipment	16,068,175	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	70,155,890	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	70,155,890	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/17/2024 11:02 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	NEW CAP REL COSTS-BLDG & FIXT	1,871,139	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,516,365	0	463,176	0	0	2.00
3.00	Total (sum of lines 1-2)	4,387,504	0	463,176	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,871,139	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,979,541	2.00
3.00	Total (sum of lines 1-2)	0	4,850,680	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 5/17/2024 11:02 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	54,087,715	0	54,087,715	0.770965	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	16,068,175	0	16,068,175	0.229035	0	2.00
3.00	Total (sum of lines 1-2)	70,155,890	0	70,155,890	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,523,921	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,017,306	180,107	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,541,227	180,107	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,523,921	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	463,176	0	0	0	2,660,589	2.00
3.00	Total (sum of lines 1-2)	463,176	0	0	0	4,184,510	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/17/2024 11:02 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-462,876	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	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)	B	-4,769	ADMINISTRATIVE & GENERAL	5.00	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)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,829,487			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	-239,349	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-1,764	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-13,028	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/17/2024 11:02 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	DIETARY	B	-15,404	DIETARY	10.00	0	33.00
33.01	PHYSICIAN RECRUITMENT	A	-193,681	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	LOBBYING DUES	A	-17,776	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	CRNA SALARY	A	-1,373,373	NONPHYSICIAN ANESTHETISTS	19.00	0	33.03
33.04	CRNA EMP BEN	A	-202,452	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	BOND INSURANCE	A	15,989	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	33.05
33.06	NON ALLLOWABLE MARKETING	A	-481,483	ADMINISTRATIVE & GENERAL	5.00	0	33.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,819,453				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: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/17/2024 11:02 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	967,604	967,604	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	77,072	77,072	0	0	0	2.00
3.00	65.03	SLEEP STUDY	41,490	41,490	0	0	0	3.00
4.00	90.01	ORTHOPAEDIC CLINIC	3,522,657	3,510,362	12,295	0	0	4.00
5.00	90.02	SURGICAL CLINIC	770,458	744,320	26,138	0	0	5.00
6.00	90.03	CARDIOLOGY CLINIC	805,954	765,657	40,297	0	0	6.00
7.00	91.00	EMERGENCY	2,301,130	722,982	1,578,148	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			8,486,365	6,829,487	1,656,878		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	65.03	SLEEP STUDY	0	0	0	0	0	3.00
4.00	90.01	ORTHOPAEDIC CLINIC	0	0	0	0	0	4.00
5.00	90.02	SURGICAL CLINIC	0	0	0	0	0	5.00
6.00	90.03	CARDIOLOGY CLINIC	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	967,604		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	77,072		2.00
3.00	65.03	SLEEP STUDY	0	0	0	41,490		3.00
4.00	90.01	ORTHOPAEDIC CLINIC	0	0	0	3,510,362		4.00
5.00	90.02	SURGICAL CLINIC	0	0	0	744,320		5.00
6.00	90.03	CARDIOLOGY CLINIC	0	0	0	765,657		6.00
7.00	91.00	EMERGENCY	0	0	0	722,982		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	6,829,487		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/17/2024 11:02 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,523,921	1,523,921				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2,660,589		2,660,589			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,453,481	1,375	0	1,454,856		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,305,166	257,600	1,630,915	150,569	12,344,250	5.00
7.00	00700	OPERATION OF PLANT	2,478,543	35,542	32,596	15,223	2,561,904	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	139,102	17,716	0	0	156,818	8.00
9.00	00900	HOUSEKEEPING	820,850	17,716	21,619	21,682	881,867	9.00
10.00	01000	DIETARY	141,402	70,672	22,016	3,285	237,375	10.00
11.00	01100	CAFETERIA	680,811	17,083	0	19,278	717,172	11.00
13.00	01300	NURSING ADMINISTRATION	738,884	5,502	0	24,933	769,319	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,624,305	0	617	20,321	1,645,243	16.00
17.00	01700	SOCIAL SERVICE	273,610	3,851	374	8,386	286,221	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	306,343	0	0	55,991	362,334	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,633,857	332,759	75,650	82,851	3,125,117	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,959,056	326,786	315,790	61,104	3,662,736	50.00
53.00	05300	ANESTHESIOLOGY	0	0	54,037	0	54,037	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,556,509	90,039	254,631	44,045	2,945,224	54.00
60.00	06000	LABORATORY	3,096,674	54,689	111,922	47,982	3,311,267	60.00
65.00	06500	RESPIRATORY THERAPY	638,807	22,723	55,694	22,305	739,529	65.00
65.01	06501	CARDIAC REHAB	207,608	21,815	0	6,291	235,714	65.01
65.02	06502	PULMONARY	209,235	0	0	3,193	212,428	65.02
65.03	06503	SLEEP STUDY	328,255	22,778	2,076	10,540	363,649	65.03
66.00	06600	PHYSICAL THERAPY	2,516,728	0	13,601	71,030	2,601,359	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,322,887	52,378	7,837	11,213	1,394,315	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,503,508	0	0	0	3,503,508	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,432,597	29,820	4,795	21,720	6,488,932	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	310,278	63,382	0	6,518	380,178	88.00
88.01	08802	RURAL HEALTH CLINIC II	2,833,512	0	0	95,726	2,929,238	88.01
88.02	08801	RURAL HEALTH CLINIC III	1,228,364	0	0	41,009	1,269,373	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,371,301	0	0	42,431	1,413,732	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,100,345	0	0	29,274	1,129,619	88.04
88.05	08805	RURAL HEALTH CLINIC VI	873,345	0	0	23,418	896,763	88.05
90.00	09000	CLINIC	1,187,690	0	0	25,232	1,212,922	90.00
90.01	09001	ORTHOPAEDIC CLINIC	3,387,282	0	0	229,301	3,616,583	90.01
90.02	09002	SURGICAL CLINIC	715,699	0	0	38,193	753,892	90.02
90.03	09003	CARDIOLOGY CLINIC	147,204	0	0	33,712	180,916	90.03
90.04	09004	SENIOR CARE CLINIC	320,316	0	0	6,488	326,804	90.04
90.05	09005	SPECIALTY CLINIC	797,547	0	0	6,365	803,912	90.05
91.00	09100	EMERGENCY	3,330,213	73,093	56,419	75,326	3,535,051	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,185,406	0	0	60,276	2,245,682	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,341,230	1,517,319	2,660,589	1,415,211	69,294,983	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,602	0	0	6,602	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OUTREACH	269,383	0	0	8,744	278,127	192.01
192.02	19202	CLINIC	987,674	0	0	30,901	1,018,575	192.02
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)	70,598,287	1,523,921	2,660,589	1,454,856	70,598,287	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/17/2024 11:02 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,344,250					5.00
7.00	00700	OPERATION OF PLANT	542,878	3,104,782				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,230	44,741	234,789			8.00
9.00	00900	HOUSEKEEPING	186,871	44,741	8,874	1,122,353		9.00
10.00	01000	DIETARY	50,301	178,478	1,634	66,433	534,221	10.00
11.00	01100	CAFETERIA	151,972	43,143	0	16,059	0	11.00
13.00	01300	NURSING ADMINISTRATION	163,022	13,895	0	5,172	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	348,634	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	60,651	9,726	0	3,620	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	76,780	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	662,225	840,353	88,500	312,795	534,221	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	776,148	825,279	42,313	307,185	0	50.00
53.00	05300	ANESTHESIOLOGY	11,451	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	624,105	227,388	23,943	84,638	0	54.00
60.00	06000	LABORATORY	701,671	138,114	1,291	51,409	0	60.00
65.00	06500	RESPIRATORY THERAPY	156,709	57,385	1,013	21,360	0	65.00
65.01	06501	CARDIAC REHAB	49,949	55,093	0	20,507	0	65.01
65.02	06502	PULMONARY	45,014	0	0	0	0	65.02
65.03	06503	SLEEP STUDY	77,059	57,524	4,135	21,412	0	65.03
66.00	06600	PHYSICAL THERAPY	551,238	0	16,670	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	295,461	132,278	0	49,236	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	742,407	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,375,018	75,310	0	28,032	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	80,561	160,068	0	59,580	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	620,717	0	654	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	268,985	0	1,030	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	299,575	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	239,371	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	190,028	0	0	0	0	88.05
90.00	09000	CLINIC	257,023	0	3,988	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	766,368	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	159,753	0	0	0	0	90.02
90.03	09003	CARDIOLOGY CLINIC	38,337	0	0	0	0	90.03
90.04	09004	SENIOR CARE CLINIC	69,251	0	0	0	0	90.04
90.05	09005	SPECIALTY CLINIC	170,352	0	0	0	0	90.05
91.00	09100	EMERGENCY	749,091	184,592	40,744	68,709	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	475,869	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,068,075	3,088,108	234,789	1,116,147	534,221	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,399	16,674	0	6,206	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OUTREACH	58,936	0	0	0	0	192.01
192.02	19202	CLINIC	215,840	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	12,344,250	3,104,782	234,789	1,122,353	534,221	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/17/2024 11:02 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	928,346					11.00
13.00	01300	NURSING ADMINISTRATION	0	951,408				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,993,877			16.00
17.00	01700	SOCIAL SERVICE	13,171	0	0	373,389		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	439,114	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	192,415	404,137	1,324,374	373,389	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	151,079	317,316	98,779	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	439,114	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	107,845	0	29,268	0	0	54.00
60.00	06000	LABORATORY	103,098	0	32,926	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	40,149	0	7,317	0	0	65.00
65.01	06501	CARDIAC REHAB	11,576	0	0	0	0	65.01
65.02	06502	PULMONARY	6,946	0	0	0	0	65.02
65.03	06503	SLEEP STUDY	13,933	0	0	0	0	65.03
66.00	06600	PHYSICAL THERAPY	0	0	36,585	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,670	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,537	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,152	0	0	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	40,243	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	41,051	0	65,853	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	51,219	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	43,670	0	32,926	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	274,387	0	0	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	0	90.02
90.03	09003	CARDIOLOGY CLINIC	18,910	0	0	0	0	90.03
90.04	09004	SENIOR CARE CLINIC	0	0	0	0	0	90.04
90.05	09005	SPECIALTY CLINIC	15,659	0	0	0	0	90.05
91.00	09100	EMERGENCY	109,485	229,955	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	928,346	951,408	1,993,877	373,389	439,114	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OUTREACH	0	0	0	0	0	192.01
192.02	19202	CLINIC	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	928,346	951,408	1,993,877	373,389	439,114	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/17/2024 11:02 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	7,857,526	0	7,857,526		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,180,835	0	6,180,835		50.00
53.00	05300	ANESTHESIOLOGY	504,602	0	504,602		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,042,411	0	4,042,411		54.00
60.00	06000	LABORATORY	4,339,776	0	4,339,776		60.00
65.00	06500	RESPIRATORY THERAPY	1,023,462	0	1,023,462		65.00
65.01	06501	CARDIAC REHAB	372,839	0	372,839		65.01
65.02	06502	PULMONARY	264,388	0	264,388		65.02
65.03	06503	SLEEP STUDY	537,712	0	537,712		65.03
66.00	06600	PHYSICAL THERAPY	3,205,852	0	3,205,852		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,896,960	0	1,896,960		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,245,915	0	4,245,915		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,992,829	0	7,992,829		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	688,539	0	688,539		88.00
88.01	08802	RURAL HEALTH CLINIC II	3,590,852	0	3,590,852		88.01
88.02	08801	RURAL HEALTH CLINIC III	1,646,292	0	1,646,292		88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,764,526	0	1,764,526		88.03
88.04	08804	RURAL HEALTH CLINIC V	1,368,990	0	1,368,990		88.04
88.05	08805	RURAL HEALTH CLINIC VI	1,086,791	0	1,086,791		88.05
90.00	09000	CLINIC	1,550,529	0	1,550,529		90.00
90.01	09001	ORTHOPAEDIC CLINIC	4,657,338	0	4,657,338		90.01
90.02	09002	SURGICAL CLINIC	913,645	0	913,645		90.02
90.03	09003	CARDIOLOGY CLINIC	238,163	0	238,163		90.03
90.04	09004	SENIOR CARE CLINIC	396,055	0	396,055		90.04
90.05	09005	SPECIALTY CLINIC	989,923	0	989,923		90.05
91.00	09100	EMERGENCY	4,917,627	0	4,917,627		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	2,721,551	0	2,721,551		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	68,995,928	0	68,995,928		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	30,881	0	30,881		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	OUTREACH	337,063	0	337,063		192.01
192.02	19202	CLINIC	1,234,415	0	1,234,415		192.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	70,598,287	0	70,598,287		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/17/2024 11:02 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,375	0	1,375	1,375	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	257,600	1,630,915	1,888,515	144	5.00
7.00	00700	OPERATION OF PLANT	0	35,542	32,596	68,138	15	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	17,716	0	17,716	0	8.00
9.00	00900	HOUSEKEEPING	0	17,716	21,619	39,335	21	9.00
10.00	01000	DIETARY	0	70,672	22,016	92,688	3	10.00
11.00	01100	CAFETERIA	0	17,083	0	17,083	18	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,502	0	5,502	24	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	617	617	19	16.00
17.00	01700	SOCIAL SERVICE	0	3,851	374	4,225	8	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	54	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	332,759	75,650	408,409	79	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	326,786	315,790	642,576	58	50.00
53.00	05300	ANESTHESIOLOGY	0	0	54,037	54,037	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	90,039	254,631	344,670	42	54.00
60.00	06000	LABORATORY	0	54,689	111,922	166,611	46	60.00
65.00	06500	RESPIRATORY THERAPY	0	22,723	55,694	78,417	21	65.00
65.01	06501	CARDIAC REHAB	0	21,815	0	21,815	6	65.01
65.02	06502	PULMONARY	0	0	0	0	3	65.02
65.03	06503	SLEEP STUDY	0	22,778	2,076	24,854	10	65.03
66.00	06600	PHYSICAL THERAPY	0	0	13,601	13,601	68	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	52,378	7,837	60,215	11	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	29,820	4,795	34,615	21	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	63,382	0	63,382	6	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	0	0	92	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	0	0	39	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	41	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	28	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	22	88.05
90.00	09000	CLINIC	0	0	0	0	24	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	0	203	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	37	90.02
90.03	09003	CARDIOLOGY CLINIC	0	0	0	0	32	90.03
90.04	09004	SENIOR CARE CLINIC	0	0	0	0	6	90.04
90.05	09005	SPECIALTY CLINIC	0	0	0	0	6	90.05
91.00	09100	EMERGENCY	0	73,093	56,419	129,512	72	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	58	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,517,319	2,660,589	4,177,908	1,337	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,602	0	6,602	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OUTREACH	0	0	0	0	8	192.01
192.02	19202	CLINIC	0	0	0	0	30	192.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,523,921	2,660,589	4,184,510	1,375	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/17/2024 11:02 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,888,659					5.00
7.00	00700	OPERATION OF PLANT	83,059	151,212				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,084	2,179	24,979			8.00
9.00	00900	HOUSEKEEPING	28,591	2,179	944	71,070		9.00
10.00	01000	DIETARY	7,696	8,692	174	4,207	113,460	10.00
11.00	01100	CAFETERIA	23,251	2,101	0	1,017	0	11.00
13.00	01300	NURSING ADMINISTRATION	24,942	677	0	327	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	53,340	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	9,280	474	0	229	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	11,747	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	101,319	40,928	9,414	19,806	113,460	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	118,750	40,193	4,502	19,452	0	50.00
53.00	05300	ANESTHESIOLOGY	1,752	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	95,487	11,074	2,547	5,359	0	54.00
60.00	06000	LABORATORY	107,355	6,727	137	3,255	0	60.00
65.00	06500	RESPIRATORY THERAPY	23,976	2,795	108	1,353	0	65.00
65.01	06501	CARDIAC REHAB	7,642	2,683	0	1,299	0	65.01
65.02	06502	PULMONARY	6,887	0	0	0	0	65.02
65.03	06503	SLEEP STUDY	11,790	2,802	440	1,356	0	65.03
66.00	06600	PHYSICAL THERAPY	84,339	0	1,774	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,205	6,442	0	3,118	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	113,587	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	210,385	3,668	0	1,775	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	12,326	7,796	0	3,773	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	94,969	0	70	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	41,154	0	110	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	45,835	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	36,623	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	29,074	0	0	0	0	88.05
90.00	09000	CLINIC	39,324	0	424	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	117,253	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	24,442	0	0	0	0	90.02
90.03	09003	CARDIOLOGY CLINIC	5,865	0	0	0	0	90.03
90.04	09004	SENIOR CARE CLINIC	10,595	0	0	0	0	90.04
90.05	09005	SPECIALTY CLINIC	26,064	0	0	0	0	90.05
91.00	09100	EMERGENCY	114,610	8,990	4,335	4,351	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	72,807	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,846,405	150,400	24,979	70,677	113,460	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	214	812	0	393	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OUTREACH	9,017	0	0	0	0	192.01
192.02	19202	CLINIC	33,023	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,888,659	151,212	24,979	71,070	113,460	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/17/2024 11:02 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	43,470					11.00
13.00	01300	NURSING ADMINISTRATION	0	31,472				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	53,976			16.00
17.00	01700	SOCIAL SERVICE	617	0	0	14,833		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	11,801	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,010	13,368	35,853	14,833		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,074	10,497	2,674	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,050	0	792	0		54.00
60.00	06000	LABORATORY	4,828	0	891	0		60.00
65.00	06500	RESPIRATORY THERAPY	1,880	0	198	0		65.00
65.01	06501	CARDIAC REHAB	542	0	0	0		65.01
65.02	06502	PULMONARY	325	0	0	0		65.02
65.03	06503	SLEEP STUDY	652	0	0	0		65.03
66.00	06600	PHYSICAL THERAPY	0	0	990	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,202	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,196	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	382	0	0	0		88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	1,089	0		88.01
88.02	08801	RURAL HEALTH CLINIC III	1,922	0	1,783	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	1,387	0		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0		88.05
90.00	09000	CLINIC	2,045	0	891	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	7,428	0		90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0		90.02
90.03	09003	CARDIOLOGY CLINIC	885	0	0	0		90.03
90.04	09004	SENIOR CARE CLINIC	0	0	0	0		90.04
90.05	09005	SPECIALTY CLINIC	733	0	0	0		90.05
91.00	09100	EMERGENCY	5,127	7,607	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,470	31,472	53,976	14,833	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	OUTREACH	0	0	0	0		192.01
192.02	19202	CLINIC	0	0	0	0		192.02
200.00		Cross Foot Adjustments					11,801	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	43,470	31,472	53,976	14,833	11,801	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/17/2024 11:02 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	766,479	0	766,479		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	845,776	0	845,776		50.00
53.00	05300	ANESTHESIOLOGY	55,789	0	55,789		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	465,021	0	465,021		54.00
60.00	06000	LABORATORY	289,850	0	289,850		60.00
65.00	06500	RESPIRATORY THERAPY	108,748	0	108,748		65.00
65.01	06501	CARDIAC REHAB	33,987	0	33,987		65.01
65.02	06502	PULMONARY	7,215	0	7,215		65.02
65.03	06503	SLEEP STUDY	41,904	0	41,904		65.03
66.00	06600	PHYSICAL THERAPY	100,772	0	100,772		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	116,193	0	116,193		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	113,587	0	113,587		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	251,660	0	251,660		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	87,665	0	87,665		88.00
88.01	08802	RURAL HEALTH CLINIC II	96,220	0	96,220		88.01
88.02	08801	RURAL HEALTH CLINIC III	45,008	0	45,008		88.02
88.03	08803	RURAL HEALTH CLINIC IV	47,263	0	47,263		88.03
88.04	08804	RURAL HEALTH CLINIC V	36,651	0	36,651		88.04
88.05	08805	RURAL HEALTH CLINIC VI	29,096	0	29,096		88.05
90.00	09000	CLINIC	42,708	0	42,708		90.00
90.01	09001	ORTHOPAEDIC CLINIC	124,884	0	124,884		90.01
90.02	09002	SURGICAL CLINIC	24,479	0	24,479		90.02
90.03	09003	CARDIOLOGY CLINIC	6,782	0	6,782		90.03
90.04	09004	SENIOR CARE CLINIC	10,601	0	10,601		90.04
90.05	09005	SPECIALTY CLINIC	26,803	0	26,803		90.05
91.00	09100	EMERGENCY	274,604	0	274,604		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	72,865	0	72,865		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,122,610	0	4,122,610		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,021	0	8,021		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	OUTREACH	9,025	0	9,025		192.01
192.02	19202	CLINIC	33,053	0	33,053		192.02
200.00		Cross Foot Adjustments	11,801	0	11,801		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	4,184,510	0	4,184,510		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/17/2024 11:02 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DEPRECIATION)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	55,396					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2,222,444				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	50	0	35,685,677			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,364	1,362,339	3,693,227	-12,344,250	58,254,037	5.00
7.00	00700	OPERATION OF PLANT	1,292	27,228	373,405	0	2,561,904	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	644	0	0	0	156,818	8.00
9.00	00900	HOUSEKEEPING	644	18,059	531,816	0	881,867	9.00
10.00	01000	DIETARY	2,569	18,390	80,580	0	237,375	10.00
11.00	01100	CAFETERIA	621	0	472,853	0	717,172	11.00
13.00	01300	NURSING ADMINISTRATION	200	0	611,577	0	769,319	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	515	498,439	0	1,645,243	16.00
17.00	01700	SOCIAL SERVICE	140	312	205,690	0	286,221	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	1,373,373	0	362,334	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,096	63,192	2,032,205	0	3,125,117	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,879	263,786	1,498,779	0	3,662,736	50.00
53.00	05300	ANESTHESIOLOGY	0	45,138	0	0	54,037	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,273	212,698	1,080,356	0	2,945,224	54.00
60.00	06000	LABORATORY	1,988	93,491	1,176,932	0	3,311,267	60.00
65.00	06500	RESPIRATORY THERAPY	826	46,522	547,106	0	739,529	65.00
65.01	06501	CARDIAC REHAB	793	0	154,301	0	235,714	65.01
65.02	06502	PULMONARY	0	0	78,312	0	212,428	65.02
65.03	06503	SLEEP STUDY	828	1,734	258,521	0	363,649	65.03
66.00	06600	PHYSICAL THERAPY	0	11,361	1,742,256	0	2,601,359	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,904	6,546	275,037	0	1,394,315	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	3,503,508	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,084	4,005	532,758	0	6,488,932	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,304	0	159,888	0	380,178	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	2,347,999	0	2,929,238	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	1,005,896	0	1,269,373	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	1,040,755	0	1,413,732	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	718,051	0	1,129,619	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	574,417	0	896,763	88.05
90.00	09000	CLINIC	0	0	618,900	0	1,212,922	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	5,624,731	0	3,616,583	90.01
90.02	09002	SURGICAL CLINIC	0	0	936,806	0	753,892	90.02
90.03	09003	CARDIOLOGY CLINIC	0	0	826,912	0	180,916	90.03
90.04	09004	SENIOR CARE CLINIC	0	0	159,141	0	326,804	90.04
90.05	09005	SPECIALTY CLINIC	0	0	156,114	0	803,912	90.05
91.00	09100	EMERGENCY	2,657	47,128	1,847,629	0	3,535,051	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	1,478,488	0	2,245,682	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,156	2,222,444	34,713,250	-12,344,250	56,950,733	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	240	0	0	0	6,602	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OUTREACH	0	0	214,483	0	278,127	192.01
192.02	19202	CLINIC	0	0	757,944	0	1,018,575	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,523,921	2,660,589	1,454,856		12,344,250	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.509586	1.197146	0.040769		0.211904	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			1,375		1,888,659	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000039		0.032421	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: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/17/2024 11:02 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	44,690					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	644	14,366				8.00
9.00	00900	HOUSEKEEPING	644	543	43,402			9.00
10.00	01000	DIETARY	2,569	100	2,569	100		10.00
11.00	01100	CAFETERIA	621	0	621	0	396,972	11.00
13.00	01300	NURSING ADMINISTRATION	200	0	200	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	140	0	140	0	5,632	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,096	5,415	12,096	100	82,279	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,879	2,589	11,879	0	64,603	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,273	1,465	3,273	0	46,116	54.00
60.00	06000	LABORATORY	1,988	79	1,988	0	44,086	60.00
65.00	06500	RESPIRATORY THERAPY	826	62	826	0	17,168	65.00
65.01	06501	CARDIAC REHAB	793	0	793	0	4,950	65.01
65.02	06502	PULMONARY	0	0	0	0	2,970	65.02
65.03	06503	SLEEP STUDY	828	253	828	0	5,958	65.03
66.00	06600	PHYSICAL THERAPY	0	1,020	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,904	0	1,904	0	10,977	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,084	0	1,084	0	10,920	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,304	0	2,304	0	3,486	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	40	0	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	63	0	0	17,554	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	244	0	0	18,674	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	0	90.02
90.03	09003	CARDIOLOGY CLINIC	0	0	0	0	8,086	90.03
90.04	09004	SENIOR CARE CLINIC	0	0	0	0	0	90.04
90.05	09005	SPECIALTY CLINIC	0	0	0	0	6,696	90.05
91.00	09100	EMERGENCY	2,657	2,493	2,657	0	46,817	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,450	14,366	43,162	100	396,972	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	240	0	240	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OUTREACH	0	0	0	0	0	192.01
192.02	19202	CLINIC	0	0	0	0	0	192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,104,782	234,789	1,122,353	534,221	928,346	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	69.473753	16.343380	25.859477	5,342.210000	2.338568	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	151,212	24,979	71,070	113,460	43,470	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.383576	1.738758	1.637482	1,134.600000	0.109504	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: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/17/2024 11:02 am

		Cost Center Description	NURSING ADMINISTRATION (NURSE FTE'S)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			13.00	16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	193,699					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	545				16.00
17.00	01700	SOCIAL SERVICE	0	0	1,602			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	82,279	362	1,602	0		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	64,603	27	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8	0	0		54.00
60.00	06000	LABORATORY	0	9	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	2	0	0		65.00
65.01	06501	CARDIAC REHAB	0	0	0	0		65.01
65.02	06502	PULMONARY	0	0	0	0		65.02
65.03	06503	SLEEP STUDY	0	0	0	0		65.03
66.00	06600	PHYSICAL THERAPY	0	10	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
88.01	08802	RURAL HEALTH CLINIC II	0	11	0	0		88.01
88.02	08801	RURAL HEALTH CLINIC III	0	18	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	14	0	0		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0		88.05
90.00	09000	CLINIC	0	9	0	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	75	0	0		90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0		90.02
90.03	09003	CARDIOLOGY CLINIC	0	0	0	0		90.03
90.04	09004	SENIOR CARE CLINIC	0	0	0	0		90.04
90.05	09005	SPECIALTY CLINIC	0	0	0	0		90.05
91.00	09100	EMERGENCY	46,817	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	193,699	545	1,602	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	OUTREACH	0	0	0	0		192.01
192.02	19202	CLINIC	0	0	0	0		192.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	951,408	1,993,877	373,389	439,114		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.911786	3,658.489908	233.076779	4,391.140000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	31,472	53,976	14,833	11,801		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.162479	99.038532	9.259051	118.010000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/17/2024 11:02 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	7,857,526		7,857,526	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,180,835		6,180,835	0	0	50.00
53.00	05300	ANESTHESIOLOGY	504,602		504,602	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,042,411		4,042,411	0	0	54.00
60.00	06000	LABORATORY	4,339,776		4,339,776	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,023,462	0	1,023,462	0	0	65.00
65.01	06501	CARDIAC REHAB	372,839	0	372,839	0	0	65.01
65.02	06502	PULMONARY	264,388	0	264,388	0	0	65.02
65.03	06503	SLEEP STUDY	537,712	0	537,712	0	0	65.03
66.00	06600	PHYSICAL THERAPY	3,205,852	0	3,205,852	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,896,960		1,896,960	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,245,915		4,245,915	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,992,829		7,992,829	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	688,539		688,539	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	3,590,852		3,590,852	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	1,646,292		1,646,292	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,764,526		1,764,526	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,368,990		1,368,990	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1,086,791		1,086,791	0	0	88.05
90.00	09000	CLINIC	1,550,529		1,550,529	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	4,657,338		4,657,338	0	0	90.01
90.02	09002	SURGICAL CLINIC	913,645		913,645	0	0	90.02
90.03	09003	CARDIOLOGY CLINIC	238,163		238,163	0	0	90.03
90.04	09004	SENIOR CARE CLINIC	396,055		396,055	0	0	90.04
90.05	09005	SPECIALTY CLINIC	989,923		989,923	0	0	90.05
91.00	09100	EMERGENCY	4,917,627		4,917,627	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	711,721		711,721		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,721,551		2,721,551	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	69,707,649	0	69,707,649	0	0	200.00
201.00		Less Observation Beds	711,721		711,721		0	201.00
202.00		Total (see instructions)	68,995,928	0	68,995,928	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/17/2024 11:02 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	2,941,016		2,941,016			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,750,919	26,732,439	30,483,358	0.202761	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	518,483	4,292,877	4,811,360	0.104877	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	807,075	28,233,662	29,040,737	0.139198	0.000000	54.00
60.00	06000	LABORATORY	1,380,711	18,008,731	19,389,442	0.223822	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	317,367	1,510,342	1,827,709	0.559970	0.000000	65.00
65.01	06501	CARDIAC REHAB	1,000	427,210	428,210	0.870692	0.000000	65.01
65.02	06502	PULMONARY	1,065	166,449	167,514	1.578304	0.000000	65.02
65.03	06503	SLEEP STUDY	0	1,952,952	1,952,952	0.275333	0.000000	65.03
66.00	06600	PHYSICAL THERAPY	1,106,150	9,684,262	10,790,412	0.297102	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,107,316	4,078,421	5,185,737	0.365803	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,003,817	14,860,313	17,864,130	0.237678	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,398,912	32,513,579	33,912,491	0.235690	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	494,454	494,454			88.00
88.01	08802	RURAL HEALTH CLINIC II	0	2,423,034	2,423,034			88.01
88.02	08801	RURAL HEALTH CLINIC III	0	958,969	958,969			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	1,090,473	1,090,473			88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,425,046	1,425,046			88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	603,581	603,581			88.05
90.00	09000	CLINIC	25	1,205,395	1,205,420	1.286298	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	300	3,542,867	3,543,167	1.314456	0.000000	90.01
90.02	09002	SURGICAL CLINIC	75	364,202	364,277	2.508105	0.000000	90.02
90.03	09003	CARDIOLOGY CLINIC	250	227,626	227,876	1.045143	0.000000	90.03
90.04	09004	SENIOR CARE CLINIC	10	340,116	340,126	1.164436	0.000000	90.04
90.05	09005	SPECIALTY CLINIC	25	185,290	185,315	5.341840	0.000000	90.05
91.00	09100	EMERGENCY	54,080	6,061,346	6,115,426	0.804135	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	362,402	362,402	1.963899	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,755,514	2,755,514	0.987675	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	16,388,596	164,501,552	180,890,148			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	16,388,596	164,501,552	180,890,148			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 14-1327	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/17/2024 11:02 am
	Title XVIII	Hospital	Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
65.01	06501	CARDIAC REHAB	0.000000		65.01
65.02	06502	PULMONARY	0.000000		65.02
65.03	06503	SLEEP STUDY	0.000000		65.03
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	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	08802	RURAL HEALTH CLINIC II			88.01
88.02	08801	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
88.04	08804	RURAL HEALTH CLINIC V			88.04
88.05	08805	RURAL HEALTH CLINIC VI			88.05
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000		90.01
90.02	09002	SURGICAL CLINIC	0.000000		90.02
90.03	09003	CARDIOLOGY CLINIC	0.000000		90.03
90.04	09004	SENIOR CARE CLINIC	0.000000		90.04
90.05	09005	SPECIALTY CLINIC	0.000000		90.05
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/17/2024 11:02 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,857,526		7,857,526	0	7,857,526	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,180,835		6,180,835	0	6,180,835	50.00
53.00	05300	ANESTHESIOLOGY	504,602		504,602	0	504,602	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,042,411		4,042,411	0	4,042,411	54.00
60.00	06000	LABORATORY	4,339,776		4,339,776	0	4,339,776	60.00
65.00	06500	RESPIRATORY THERAPY	1,023,462	0	1,023,462	0	1,023,462	65.00
65.01	06501	CARDIAC REHAB	372,839	0	372,839	0	372,839	65.01
65.02	06502	PULMONARY	264,388	0	264,388	0	264,388	65.02
65.03	06503	SLEEP STUDY	537,712	0	537,712	0	537,712	65.03
66.00	06600	PHYSICAL THERAPY	3,205,852	0	3,205,852	0	3,205,852	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,896,960		1,896,960	0	1,896,960	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,245,915		4,245,915	0	4,245,915	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,992,829		7,992,829	0	7,992,829	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	688,539		688,539	0	688,539	88.00
88.01	08802	RURAL HEALTH CLINIC II	3,590,852		3,590,852	0	3,590,852	88.01
88.02	08801	RURAL HEALTH CLINIC III	1,646,292		1,646,292	0	1,646,292	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,764,526		1,764,526	0	1,764,526	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,368,990		1,368,990	0	1,368,990	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1,086,791		1,086,791	0	1,086,791	88.05
90.00	09000	CLINIC	1,550,529		1,550,529	0	1,550,529	90.00
90.01	09001	ORTHOPAEDIC CLINIC	4,657,338		4,657,338	0	4,657,338	90.01
90.02	09002	SURGICAL CLINIC	913,645		913,645	0	913,645	90.02
90.03	09003	CARDIOLOGY CLINIC	238,163		238,163	0	238,163	90.03
90.04	09004	SENIOR CARE CLINIC	396,055		396,055	0	396,055	90.04
90.05	09005	SPECIALTY CLINIC	989,923		989,923	0	989,923	90.05
91.00	09100	EMERGENCY	4,917,627		4,917,627	0	4,917,627	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	711,721		711,721		711,721	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,721,551		2,721,551	0	2,721,551	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	69,707,649	0	69,707,649	0	69,707,649	200.00
201.00		Less Observation Beds	711,721		711,721		711,721	201.00
202.00		Total (see instructions)	68,995,928	0	68,995,928	0	68,995,928	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/17/2024 11:02 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,941,016		2,941,016			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,750,919	26,732,439	30,483,358	0.202761	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	518,483	4,292,877	4,811,360	0.104877	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	807,075	28,233,662	29,040,737	0.139198	0.000000	54.00
60.00	06000	LABORATORY	1,380,711	18,008,731	19,389,442	0.223822	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	317,367	1,510,342	1,827,709	0.559970	0.000000	65.00
65.01	06501	CARDIAC REHAB	1,000	427,210	428,210	0.870692	0.000000	65.01
65.02	06502	PULMONARY	1,065	166,449	167,514	1.578304	0.000000	65.02
65.03	06503	SLEEP STUDY	0	1,952,952	1,952,952	0.275333	0.000000	65.03
66.00	06600	PHYSICAL THERAPY	1,106,150	9,684,262	10,790,412	0.297102	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,107,316	4,078,421	5,185,737	0.365803	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,003,817	14,860,313	17,864,130	0.237678	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,398,912	32,513,579	33,912,491	0.235690	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	494,454	494,454	1.392524	0.000000	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	2,423,034	2,423,034	1.481965	0.000000	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	958,969	958,969	1.716731	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	1,090,473	1,090,473	1.618129	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,425,046	1,425,046	0.960664	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	603,581	603,581	1.800572	0.000000	88.05
90.00	09000	CLINIC	25	1,205,395	1,205,420	1.286298	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	300	3,542,867	3,543,167	1.314456	0.000000	90.01
90.02	09002	SURGICAL CLINIC	75	364,202	364,277	2.508105	0.000000	90.02
90.03	09003	CARDIOLOGY CLINIC	250	227,626	227,876	1.045143	0.000000	90.03
90.04	09004	SENIOR CARE CLINIC	10	340,116	340,126	1.164436	0.000000	90.04
90.05	09005	SPECIALTY CLINIC	25	185,290	185,315	5.341840	0.000000	90.05
91.00	09100	EMERGENCY	54,080	6,061,346	6,115,426	0.804135	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	362,402	362,402	1.963899	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,755,514	2,755,514	0.987675	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	16,388,596	164,501,552	180,890,148			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	16,388,596	164,501,552	180,890,148			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/17/2024 11:02 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
65.01	06501	CARDIAC REHAB	0.000000		65.01
65.02	06502	PULMONARY	0.000000		65.02
65.03	06503	SLEEP STUDY	0.000000		65.03
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08802	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08801	RURAL HEALTH CLINIC III	0.000000		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		88.05
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000		90.01
90.02	09002	SURGICAL CLINIC	0.000000		90.02
90.03	09003	CARDIOLOGY CLINIC	0.000000		90.03
90.04	09004	SENIOR CARE CLINIC	0.000000		90.04
90.05	09005	SPECIALTY CLINIC	0.000000		90.05
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/17/2024 11:02 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	845,776	30,483,358	0.027745	1,794,896	49,799	50.00
53.00	05300	ANESTHESIOLOGY	55,789	4,811,360	0.011595	264,109	3,062	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	465,021	29,040,737	0.016013	476,147	7,625	54.00
60.00	06000	LABORATORY	289,850	19,389,442	0.014949	874,895	13,079	60.00
65.00	06500	RESPIRATORY THERAPY	108,748	1,827,709	0.059500	203,590	12,114	65.00
65.01	06501	CARDIAC REHAB	33,987	428,210	0.079370	0	0	65.01
65.02	06502	PULMONARY	7,215	167,514	0.043071	7	0	65.02
65.03	06503	SLEEP STUDY	41,904	1,952,952	0.021457	0	0	65.03
66.00	06600	PHYSICAL THERAPY	100,772	10,790,412	0.009339	479,016	4,474	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	116,193	5,185,737	0.022406	572,297	12,823	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	113,587	17,864,130	0.006358	1,604,010	10,198	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	251,660	33,912,491	0.007421	787,383	5,843	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	87,665	494,454	0.177297	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	96,220	2,423,034	0.039711	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	45,008	958,969	0.046934	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	47,263	1,090,473	0.043342	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	36,651	1,425,046	0.025719	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	29,096	603,581	0.048206	0	0	88.05
90.00	09000	CLINIC	42,708	1,205,420	0.035430	11	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	124,884	3,543,167	0.035246	262	9	90.01
90.02	09002	SURGICAL CLINIC	24,479	364,277	0.067199	42	3	90.02
90.03	09003	CARDIOLOGY CLINIC	6,782	227,876	0.029762	217	6	90.03
90.04	09004	SENIOR CARE CLINIC	10,601	340,126	0.031168	1	0	90.04
90.05	09005	SPECIALTY CLINIC	26,803	185,315	0.144635	7	1	90.05
91.00	09100	EMERGENCY	274,604	6,115,426	0.044903	6	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	69,426	362,402	0.191572	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	3,352,692	175,193,618		7,056,896	119,036	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/17/2024 11:02 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	439,114	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	CARDIAC REHAB	0	0	0	0	0	65.01
65.02	06502	PULMONARY	0	0	0	0	0	65.02
65.03	06503	SLEEP STUDY	0	0	0	0	0	65.03
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	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	08802	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	0	90.02
90.03	09003	CARDIOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	SENIOR CARE CLINIC	0	0	0	0	0	90.04
90.05	09005	SPECIALTY CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	439,114	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/17/2024 11:02 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	30,483,358	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	439,114	0	4,811,360	0.091266	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,040,737	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	19,389,442	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,827,709	0.000000	65.00
65.01	06501	CARDIAC REHAB	0	0	0	428,210	0.000000	65.01
65.02	06502	PULMONARY	0	0	0	167,514	0.000000	65.02
65.03	06503	SLEEP STUDY	0	0	0	1,952,952	0.000000	65.03
66.00	06600	PHYSICAL THERAPY	0	0	0	10,790,412	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,185,737	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	17,864,130	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	33,912,491	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	494,454	0.000000	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	0	2,423,034	0.000000	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	0	958,969	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	1,090,473	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	1,425,046	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	603,581	0.000000	88.05
90.00	09000	CLINIC	0	0	0	1,205,420	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	3,543,167	0.000000	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	364,277	0.000000	90.02
90.03	09003	CARDIOLOGY CLINIC	0	0	0	227,876	0.000000	90.03
90.04	09004	SENIOR CARE CLINIC	0	0	0	340,126	0.000000	90.04
90.05	09005	SPECIALTY CLINIC	0	0	0	185,315	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	6,115,426	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	362,402	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	439,114	0	175,193,618		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/17/2024 11:02 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	1,794,896	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	264,109	24,104	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	476,147	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	874,895	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	203,590	0	0	0	65.00
65.01	06501	CARDIAC REHAB	0.000000	0	0	0	0	65.01
65.02	06502	PULMONARY	0.000000	7	0	0	0	65.02
65.03	06503	SLEEP STUDY	0.000000	0	0	0	0	65.03
66.00	06600	PHYSICAL THERAPY	0.000000	479,016	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	572,297	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	1,604,010	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	787,383	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	08802	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0	88.05
90.00	09000	CLINIC	0.000000	11	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000	262	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	0.000000	42	0	0	0	90.02
90.03	09003	CARDIOLOGY CLINIC	0.000000	217	0	0	0	90.03
90.04	09004	SENIOR CARE CLINIC	0.000000	1	0	0	0	90.04
90.05	09005	SPECIALTY CLINIC	0.000000	7	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	6	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		7,056,896	24,104	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/17/2024 11:02 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	0.202761	0	10,077,981	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.104877	0	1,461,433	2	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139198	0	10,286,551	0	0	54.00
60.00	06000	LABORATORY	0.223822	0	6,651,796	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.559970	0	646,954	0	0	65.00
65.01	06501	CARDIAC REHAB	0.870692	0	273,922	0	0	65.01
65.02	06502	PULMONARY	1.578304	0	66,016	0	0	65.02
65.03	06503	SLEEP STUDY	0.275333	0	482,350	0	0	65.03
66.00	06600	PHYSICAL THERAPY	0.297102	0	3,027,392	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.365803	0	1,583,383	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.237678	0	6,921,361	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235690	0	17,032,090	3,323	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08802	RURAL HEALTH CLINIC II						88.01
88.02	08801	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
88.04	08804	RURAL HEALTH CLINIC V						88.04
88.05	08805	RURAL HEALTH CLINIC VI						88.05
90.00	09000	CLINIC	1.286298	0	467,674	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.314456	0	1,377,337	3	0	90.01
90.02	09002	SURGICAL CLINIC	2.508105	0	141,759	0	0	90.02
90.03	09003	CARDIOLOGY CLINIC	1.045143	0	89,769	0	0	90.03
90.04	09004	SENIOR CARE CLINIC	1.164436	0	313,792	0	0	90.04
90.05	09005	SPECIALTY CLINIC	5.341840	0	73,059	0	0	90.05
91.00	09100	EMERGENCY	0.804135	0	1,885,442	155	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.963899	0	150,461	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.987675		0			95.00
200.00		Subtotal (see instructions)		0	63,010,522	3,483	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	63,010,522	3,483	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/17/2024 11:02 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	2,043,422	0		50.00
53.00	05300	ANESTHESIOLOGY	153,271	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,431,867	0		54.00
60.00	06000	LABORATORY	1,488,818	0		60.00
65.00	06500	RESPIRATORY THERAPY	362,275	0		65.00
65.01	06501	CARDIAC REHAB	238,502	0		65.01
65.02	06502	PULMONARY	104,193	0		65.02
65.03	06503	SLEEP STUDY	132,807	0		65.03
66.00	06600	PHYSICAL THERAPY	899,444	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	579,206	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,645,055	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,014,293	783		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08802	RURAL HEALTH CLINIC II				88.01
88.02	08801	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
88.04	08804	RURAL HEALTH CLINIC V				88.04
88.05	08805	RURAL HEALTH CLINIC VI				88.05
90.00	09000	CLINIC	601,568	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	1,810,449	4		90.01
90.02	09002	SURGICAL CLINIC	355,546	0		90.02
90.03	09003	CARDIOLOGY CLINIC	93,821	0		90.03
90.04	09004	SENIOR CARE CLINIC	365,391	0		90.04
90.05	09005	SPECIALTY CLINIC	390,269	0		90.05
91.00	09100	EMERGENCY	1,516,150	125		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	295,490	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	18,521,837	912		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	18,521,837	912		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/17/2024 11:02 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.202761	0	234,504	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.104877	0	42,853	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139198	0	409,651	0	0	54.00
60.00	06000	LABORATORY	0.223822	0	319,991	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.559970	0	28,919	0	0	65.00
65.01	06501	CARDIAC REHAB	0.870692	0	0	0	0	65.01
65.02	06502	PULMONARY	1.578304	0	0	0	0	65.02
65.03	06503	SLEEP STUDY	0.275333	0	29,501	0	0	65.03
66.00	06600	PHYSICAL THERAPY	0.297102	0	159,819	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.365803	0	54,578	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.237678	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235690	0	108,597	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08802	RURAL HEALTH CLINIC II						88.01
88.02	08801	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
88.04	08804	RURAL HEALTH CLINIC V						88.04
88.05	08805	RURAL HEALTH CLINIC VI						88.05
90.00	09000	CLINIC	1.286298	0	54,992	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.314456	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	2.508105	0	0	0	0	90.02
90.03	09003	CARDIOLOGY CLINIC	1.045143	0	0	0	0	90.03
90.04	09004	SENIOR CARE CLINIC	1.164436	0	0	0	0	90.04
90.05	09005	SPECIALTY CLINIC	5.341840	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.804135	0	179,212	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.963899	0	192	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.987675	0	0			95.00
200.00		Subtotal (see instructions)		0	1,622,809	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	1,622,809	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/17/2024 11:02 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	47,548	0		50.00
53.00	05300	ANESTHESIOLOGY	4,494	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,023	0		54.00
60.00	06000	LABORATORY	71,621	0		60.00
65.00	06500	RESPIRATORY THERAPY	16,194	0		65.00
65.01	06501	CARDIAC REHAB	0	0		65.01
65.02	06502	PULMONARY	0	0		65.02
65.03	06503	SLEEP STUDY	8,123	0		65.03
66.00	06600	PHYSICAL THERAPY	47,483	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,965	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,595	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08802	RURAL HEALTH CLINIC II				88.01
88.02	08801	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
88.04	08804	RURAL HEALTH CLINIC V				88.04
88.05	08805	RURAL HEALTH CLINIC VI				88.05
90.00	09000	CLINIC	70,736	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0		90.01
90.02	09002	SURGICAL CLINIC	0	0		90.02
90.03	09003	CARDIOLOGY CLINIC	0	0		90.03
90.04	09004	SENIOR CARE CLINIC	0	0		90.04
90.05	09005	SPECIALTY CLINIC	0	0		90.05
91.00	09100	EMERGENCY	144,111	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	377	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	513,270	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	513,270	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1327	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/17/2024 11:02 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)	2,392	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,807	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,602	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	448	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	137	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,147	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)	448	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	208.70	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,857,526	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)	28,592	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)	1,583,963	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,273,563	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)	6,273,563	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)	3,471.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,982,166	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,982,166	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/17/2024 11:02 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,686,963	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)	5,669,129	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)	1,555,371	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	1,555,371	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)	205	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,471.81	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/17/2024 11:02 am

Title XVIII | Hospital | Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	711,721	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	766,479	7,857,526	0.097547	711,721	69,426	90.00
91.00	Nursing Program cost	0	7,857,526	0.000000	711,721	0	91.00
92.00	Allied health cost	0	7,857,526	0.000000	711,721	0	92.00
93.00	All other Medical Education	0	7,857,526	0.000000	711,721	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1327	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/17/2024 11:02 am
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,392	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,807	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,602	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	448	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	137	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)	5	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	208.70	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	208.70	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,857,526	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)	28,592	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)	1,583,963	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,273,563	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)	6,273,563	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)	3,471.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	17,359	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)	17,359	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/17/2024 11:02 am

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	25,247	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)	42,606	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	205	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,471.81	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1327	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/17/2024 11:02 am
	Title XIX	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	711,721	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	766,479	7,857,526	0.097547	711,721	69,426	90.00
91.00	Nursing Program cost	0	7,857,526	0.000000	711,721	0	91.00
92.00	Allied health cost	0	7,857,526	0.000000	711,721	0	92.00
93.00	All other Medical Education	0	7,857,526	0.000000	711,721	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/17/2024 11:02 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,895,982		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.202761	1,794,896	363,935	50.00
53.00	05300	ANESTHESIOLOGY	0.104877	264,109	27,699	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139198	476,147	66,279	54.00
60.00	06000	LABORATORY	0.223822	874,895	195,821	60.00
65.00	06500	RESPIRATORY THERAPY	0.559970	203,590	114,004	65.00
65.01	06501	CARDIAC REHAB	0.870692	0	0	65.01
65.02	06502	PULMONARY	1.578304	7	11	65.02
65.03	06503	SLEEP STUDY	0.275333	0	0	65.03
66.00	06600	PHYSICAL THERAPY	0.297102	479,016	142,317	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.365803	572,297	209,348	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.237678	1,604,010	381,238	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235690	787,383	185,578	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0	88.05
90.00	09000	CLINIC	1.286298	11	14	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.314456	262	344	90.01
90.02	09002	SURGICAL CLINIC	2.508105	42	105	90.02
90.03	09003	CARDIOLOGY CLINIC	1.045143	217	227	90.03
90.04	09004	SENIOR CARE CLINIC	1.164436	1	1	90.04
90.05	09005	SPECIALTY CLINIC	5.341840	7	37	90.05
91.00	09100	EMERGENCY	0.804135	6	5	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.963899	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,056,896	1,686,963	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)		7,056,896		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1327 | Component CCN: 14-Z327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/17/2024 11:02 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	0.202761	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.104877	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139198	34,305	4,775	54.00
60.00	06000	LABORATORY	0.223822	74,868	16,757	60.00
65.00	06500	RESPIRATORY THERAPY	0.559970	37,281	20,876	65.00
65.01	06501	CARDIAC REHAB	0.870692	0	0	65.01
65.02	06502	PULMONARY	1.578304	0	0	65.02
65.03	06503	SLEEP STUDY	0.275333	0	0	65.03
66.00	06600	PHYSICAL THERAPY	0.297102	362,495	107,698	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.365803	55,137	20,169	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.237678	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235690	128,026	30,174	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0	88.05
90.00	09000	CLINIC	1.286298	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.314456	0	0	90.01
90.02	09002	SURGICAL CLINIC	2.508105	0	0	90.02
90.03	09003	CARDIOLOGY CLINIC	1.045143	0	0	90.03
90.04	09004	SENIOR CARE CLINIC	1.164436	0	0	90.04
90.05	09005	SPECIALTY CLINIC	5.341840	0	0	90.05
91.00	09100	EMERGENCY	0.804135	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.963899	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		692,112	200,449	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)		692,112		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/17/2024 11:02 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		7,020		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.202761	24,539	4,976	50.00
53.00	05300	ANESTHESIOLOGY	0.104877	5,235	549	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139198	4,849	675	54.00
60.00	06000	LABORATORY	0.223822	3,193	715	60.00
65.00	06500	RESPIRATORY THERAPY	0.559970	196	110	65.00
65.01	06501	CARDIAC REHAB	0.870692	0	0	65.01
65.02	06502	PULMONARY	1.578304	0	0	65.02
65.03	06503	SLEEP STUDY	0.275333	0	0	65.03
66.00	06600	PHYSICAL THERAPY	0.297102	1,152	342	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.365803	41,786	15,285	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.237678	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.235690	4,660	1,098	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.392524	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	1.481965	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	1.716731	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1.618129	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.960664	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1.800572	0	0	88.05
90.00	09000	CLINIC	1.286298	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.314456	0	0	90.01
90.02	09002	SURGICAL CLINIC	2.508105	0	0	90.02
90.03	09003	CARDIOLOGY CLINIC	1.045143	0	0	90.03
90.04	09004	SENIOR CARE CLINIC	1.164436	0	0	90.04
90.05	09005	SPECIALTY CLINIC	5.341840	0	0	90.05
91.00	09100	EMERGENCY	0.804135	1,862	1,497	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.963899	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		87,472	25,247	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)		87,472		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1327	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/17/2024 11:02 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	18,522,749	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)	18,522,749	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)	18,707,976	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)	147,806	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	11,321,941	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)	7,238,229	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)	7,238,229	30.00
31.00	Primary payer payments	2,093	31.00
32.00	Subtotal (line 30 minus line 31)	7,236,136	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)	778,848	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	506,251	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	690,530	36.00
37.00	Subtotal (see instructions)	7,742,387	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)	7,742,387	40.00
40.01	Sequestration adjustment (see instructions)	154,848	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	9,330,209	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)	-1,742,670	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	272,597	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: 14-1327	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/17/2024 11:02 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: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 5/17/2024 11:02 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		4,874,072		8,665,840	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	12/15/2023	993,443	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	08/24/2023	384,179	08/24/2023	329,074	3.50
3.51		12/15/2023	50,659		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)		-434,838		664,369	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,439,234		9,330,209	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		823,141		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1,742,670	6.02
7.00	Total Medicare program liability (see instructions)		5,262,375		7,587,539	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: 14-1327 | Component CCN: 14-Z327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/17/2024 11:02 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		1,330,752		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/24/2023	195,692		0	3.01
3.02		12/15/2023	29,928		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)		225,620		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,556,372		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		171,204		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,727,576		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: 14-1327	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/17/2024 11:02 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: 14-1327 | Component CCN: 14-Z327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/17/2024 11:02 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)	1,570,925	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)	202,453	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	448	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,773,378	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,773,378	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,773,378	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	10,600	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,762,778	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)	84	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	55	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	84	0	18.00
19.00	Total (see instructions)	1,762,833	0	19.00
19.01	Sequestration adjustment (see instructions)	35,257	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	1,556,372	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)	171,204	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: 14-1327	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/17/2024 11:02 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,669,129	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)	5,669,129	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,725,820	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)	5,725,820	19.00
20.00	Deductibles (exclude professional component)	392,890	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	5,332,930	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	5,332,930	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	56,677	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	36,840	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	50,741	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,369,770	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)	5,369,770	30.00
30.01	Sequestration adjustment (see instructions)	107,395	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	4,439,234	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)	823,141	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	19,837	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/17/2024 11:02 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	10,147,769	0	0	0	1.00
2.00	Temporary investments	23,547,466	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	38,412,129	0	0	0	4.00
5.00	Other receivable	62,424	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-23,769,942	0	0	0	6.00
7.00	Inventory	1,393,065	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,366,145	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	51,159,056	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	972,752	0	0	0	12.00
13.00	Land improvements	2,527,748	0	0	0	13.00
14.00	Accumulated depreciation	-1,467,627	0	0	0	14.00
15.00	Buildings	46,214,004	0	0	0	15.00
16.00	Accumulated depreciation	-15,842,726	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	-2,673,441	0	0	0	18.00
19.00	Fixed equipment	4,373,211	0	0	0	19.00
20.00	Accumulated depreciation	-5,216,891	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	16,068,175	0	0	0	23.00
24.00	Accumulated depreciation	800,498	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	45,755,703	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	96,914,759	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,080,932	0	0	0	37.00
38.00	Salaries, wages, and fees payable	19,074,220	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	34,767	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	2,679,509	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	23,869,428	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,955,000	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)	1,955,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,824,428	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	71,090,331				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)	71,090,331	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	96,914,759	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/17/2024 11:02 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		62,017,848		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,072,482				2.00
3.00	Total (sum of line 1 and line 2)		71,090,330		0		3.00
4.00	ROUDNING	1		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)		1		0		10.00
11.00	Subtotal (line 3 plus line 10)		71,090,331		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		71,090,331		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	ROUDNING		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1327 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/17/2024 11:02 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,009,393		4,009,393	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,009,393		4,009,393	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)	4,009,393		4,009,393	17.00
18.00	Ancillary services	12,887,024	144,957,130	157,844,154	18.00
19.00	Outpatient services	0	27,095,560	27,095,560	19.00
20.00	RURAL HEALTH CLINIC	0	494,454	494,454	20.00
20.01	RURAL HEALTH CLINIC II	0	2,423,034	2,423,034	20.01
20.02	RURAL HEALTH CLINIC III	0	958,969	958,969	20.02
20.03	RURAL HEALTH CLINIC IV	0	1,090,473	1,090,473	20.03
20.04	RURAL HEALTH CLINIC V	0	1,425,046	1,425,046	20.04
20.05	RURAL HEALTH CLINIC VI	0	603,581	603,581	20.05
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	2,755,514	2,755,514	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	16,896,417	181,803,761	198,700,178	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		80,417,740		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)		80,417,740		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1327	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/17/2024 11:02 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	198,700,178	1.00
2.00	Less contractual allowances and discounts on patients' accounts	112,727,007	2.00
3.00	Net patient revenues (line 1 minus line 2)	85,973,171	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	80,417,740	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,555,431	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	992,865	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	4,769	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	254,753	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	1,764	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	13,028	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	58,700	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	2,202,724	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	3,528,603	25.00
26.00	Total (line 5 plus line 25)	9,084,034	26.00
27.00	NONOPERATING GAINS LOSSES	11,552	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	11,552	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,072,482	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327 | Component CCN: 14-8501 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/17/2024 11:02 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	0	125,798	125,798	0	125,798	1.00
2.00	Physician Assistant	0	0	0	16,695	16,695	2.00
3.00	Nurse Practitioner	0	0	0	1,350	1,350	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	79,071	79,071	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)	0	125,798	125,798	97,116	222,914	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	6,342	6,342	0	6,342	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	6,342	6,342	0	6,342	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	132,140	132,140	97,116	229,256	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	1,307	1,307	0	1,307	29.00
30.00	Administrative Costs	105,063	15,888	120,951	-97,115	23,836	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	105,063	17,195	122,258	-97,115	25,143	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	105,063	149,335	254,398	1	254,399	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1327 | Component CCN: 14-8501 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/17/2024 11:02 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	0	125,798		1.00
2.00	Physician Assistant	54,824	71,519		2.00
3.00	Nurse Practitioner	0	1,350		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	79,071		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)	54,824	277,738		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	6,342		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	6,342		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	54,824	284,080		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	1,055	2,362		29.00
30.00	Administrative Costs	0	23,836		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,055	26,198		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	55,879	310,278		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327 | Component CCN: 14-8568 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/17/2024 11:02 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	0	0	0	1,172,081	1,172,081	1.00
2.00	Physician Assistant	0	0	0	276,110	276,110	2.00
3.00	Nurse Practitioner	0	0	0	140,446	140,446	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	300,479	300,479	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	356,514	356,514	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	2,245,630	2,245,630	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	60,661	60,661	0	60,661	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	60,661	60,661	0	60,661	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	60,661	60,661	2,245,630	2,306,291	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	3,892	3,892	0	3,892	29.00
30.00	Administrative Costs	2,346,560	395,259	2,741,819	-2,245,630	496,189	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	2,346,560	399,151	2,745,711	-2,245,630	500,081	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,346,560	459,812	2,806,372	0	2,806,372	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327 | Component CCN: 14-8568 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/17/2024 11:02 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	1,439	1,173,520		1.00
2.00	Physician Assistant	0	276,110		2.00
3.00	Nurse Practitioner	0	140,446		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	300,479		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	356,514		9.00
10.00	Subtotal (sum of lines 1 through 9)	1,439	2,247,069		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	60,661		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	60,661		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,439	2,307,730		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	25,701	29,593		29.00
30.00	Administrative Costs	0	496,189		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	25,701	525,782		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	27,140	2,833,512		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327 | Component CCN: 14-8579 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/17/2024 11:02 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	0	0	0	556,461	556,461	1.00
2.00	Physician Assistant	0	0	0	123,229	123,229	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	67,082	67,082	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	257,651	257,651	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	1,004,423	1,004,423	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	30,682	30,682	0	30,682	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	30,682	30,682	0	30,682	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	30,682	30,682	1,004,423	1,035,105	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	10,257	10,257	0	10,257	29.00
30.00	Administrative Costs	1,005,896	189,362	1,195,258	-1,004,423	190,835	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,005,896	199,619	1,205,515	-1,004,423	201,092	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,005,896	230,301	1,236,197	0	1,236,197	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1327 | Component CCN: 14-8579 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/17/2024 11:02 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	556,461		1.00
2.00	Physician Assistant	0	123,229		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	67,082		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	257,651		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,004,423		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	30,682		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	30,682		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,035,105		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	10,257		29.00
30.00	Administrative Costs	-7,833	183,002		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-7,833	193,259		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-7,833	1,228,364		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327 | Component CCN: 14-8599 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/17/2024 11:02 am

RHC IV | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	281,900	281,900	1.00
2.00	Physician Assistant	0	0	0	390,813	390,813	2.00
3.00	Nurse Practitioner	0	0	0	116,809	116,809	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	163,442	163,442	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)	0	0	0	952,964	952,964	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	33,910	33,910	0	33,910	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	33,910	33,910	0	33,910	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	33,910	33,910	952,964	986,874	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	14,690	14,690	0	14,690	29.00
30.00	Administrative Costs	1,095,580	228,202	1,323,782	-952,964	370,818	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,095,580	242,892	1,338,472	-952,964	385,508	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,095,580	276,802	1,372,382	0	1,372,382	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1327 | Component CCN: 14-8599 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/17/2024 11:02 am

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	281,900		1.00
2.00	Physician Assistant	-54,825	335,988		2.00
3.00	Nurse Practitioner	0	116,809		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	163,442		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)	-54,825	898,139		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	33,910		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	33,910		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-54,825	932,049		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	61,425	76,115		29.00
30.00	Administrative Costs	-7,681	363,137		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	53,744	439,252		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,081	1,371,301		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1327 | Component CCN: 14-8601 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/17/2024 11:02 am

RHC V | 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	0	0	0	190,554	190,554	1.00
2.00	Physician Assistant	0	0	0	9,872	9,872	2.00
3.00	Nurse Practitioner	0	0	0	105,558	105,558	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	183,540	183,540	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	21,650	21,650	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	81,108	81,108	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	592,282	592,282	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	28,078	28,078	0	28,078	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	28,078	28,078	0	28,078	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	28,078	28,078	592,282	620,360	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	19,588	19,588	0	19,588	29.00
30.00	Administrative Costs	718,051	298,338	1,016,389	-592,282	424,107	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	718,051	317,926	1,035,977	-592,282	443,695	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	718,051	346,004	1,064,055	0	1,064,055	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1327 | Component CCN: 14-8601 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/17/2024 11:02 am

RHC V | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	190,554		1.00
2.00	Physician Assistant	0	9,872		2.00
3.00	Nurse Practitioner	0	105,558		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	183,540		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	21,650		8.00
9.00	Other Facility Health Care Staff Costs	0	81,108		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	592,282		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	28,078		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	28,078		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	620,360		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	54,104	73,692		29.00
30.00	Administrative Costs	-17,814	406,293		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	36,290	479,985		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	36,290	1,100,345		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327 | Component CCN: 14-8613 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/17/2024 11:02 am

RHC VI | 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	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	263,210	263,210	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	167,377	167,377	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	143	143	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	430,730	430,730	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	29,460	29,460	0	29,460	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	29,460	29,460	0	29,460	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	29,460	29,460	430,730	460,190	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	17,323	17,323	0	17,323	29.00
30.00	Administrative Costs	574,417	228,994	803,411	-430,730	372,681	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	574,417	246,317	820,734	-430,730	390,004	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	574,417	275,777	850,194	0	850,194	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1327 | Component CCN: 14-8613 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/17/2024 11:02 am

RHC VI | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	263,210		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	167,377		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	143		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	430,730		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	29,460		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	29,460		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	460,190		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	35,086	52,409		29.00
30.00	Administrative Costs	-11,935	360,746		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	23,151	413,155		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	23,151	873,345		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327 | Component CCN: 14-8501 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/17/2024 11:02 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	0.35	1,500	4,200	1,470		1.00
2.00	Physician Assistant	0.42	1,867	2,100	882		2.00
3.00	Nurse Practitioner	0.01	9	2,100	21		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.78	3,376		2,373	3,376	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)	0.78	3,376			3,376	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)	284,080	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	284,080	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	26,198	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	378,261	15.00
16.00	Total overhead (sum of lines 14 and 15)	404,459	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	404,459	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	404,459	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	688,539	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327 | Component CCN: 14-8568 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/17/2024 11:02 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	2.61	6,014	1	3		1.00
2.00	Physician Assistant	1.46	3,368	1	1		2.00
3.00	Nurse Practitioner	0.84	2,130	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.91	11,512		5	11,512	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)	4.91	11,512			11,512	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)	2,307,730	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	2,307,730	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	525,782	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	757,340	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,283,122	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,283,122	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,283,122	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	3,590,852	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327 | Component CCN: 14-8579 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/17/2024 11:02 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	0.90	3,908	4,200	3,780		1.00
2.00	Physician Assistant	0.80	2,073	2,100	1,680		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.70	5,981		5,460	5,981	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)	1.70	5,981			5,981	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)	1,035,105	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,035,105	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	193,259	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	417,928	15.00
16.00	Total overhead (sum of lines 14 and 15)	611,187	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	611,187	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	611,187	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,646,292	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327 | Component CCN: 14-8599 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/17/2024 11:02 am

RHC IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.96	2,642	4,200	4,032		1.00
2.00	Physician Assistant	0.53	2,938	2,100	1,113		2.00
3.00	Nurse Practitioner	0.86	1,709	2,100	1,806		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.35	7,289		6,951	7,289	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)	2.35	7,289			7,289	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)	932,049	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	932,049	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	439,252	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	393,225	15.00
16.00	Total overhead (sum of lines 14 and 15)	832,477	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	832,477	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	832,477	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,764,526	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327 | Component CCN: 14-8601 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/17/2024 11:02 am

RHC V | 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	0.68	2,867	4,200	2,856		1.00
2.00	Physician Assistant	0.10	318	2,100	210		2.00
3.00	Nurse Practitioner	0.67	1,347	2,100	1,407		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.45	4,532		4,473	4,532	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)	1.45	4,532			4,532	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)	620,360	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	620,360	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	479,985	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	268,645	15.00
16.00	Total overhead (sum of lines 14 and 15)	748,630	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	748,630	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	748,630	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,368,990	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327 | Component CCN: 14-8613 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/17/2024 11:02 am

RHC VI | 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	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.66	3,749	2,100	3,486		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.66	3,749		3,486	3,749	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)	1.66	3,749			3,749	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)	460,190	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	460,190	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	413,155	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	213,446	15.00
16.00	Total overhead (sum of lines 14 and 15)	626,601	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	626,601	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	626,601	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,086,791	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1327 Component CCN: 14-8501	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/17/2024 11:02 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)		688,539	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		688,539	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,376	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)		3,376	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		203.95	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	197.37	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	197.37	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	459	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	90,593	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	90,593	16.00
16.01	Total program charges (see instructions)(from contractor's records)		62,992	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		600	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		863	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.)		64,606	16.04
16.05	Total program cost (see instructions)	0	65,469	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		8,972	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		10,653	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		65,469	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		65,469	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		65,469	26.00
26.01	Sequestration adjustment (see instructions)		1,309	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		47,391	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)		16,769	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: 14-1327 Component CCN: 14-8568	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/17/2024 11:02 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)		3,590,852	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		25,512	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		3,565,340	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		11,512	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)		11,512	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		309.71	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	381.13	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	309.71	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,539	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	476,644	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	476,644	16.00
16.01	Total program charges (see instructions)(from contractor's records)		234,803	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		14,933	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		30,314	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.)		343,985	16.04
16.05	Total program cost (see instructions)	0	374,299	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		16,349	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		40,684	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		374,299	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		17,195	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		391,494	22.00
23.00	Allowable bad debts (see instructions)		700	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		455	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		-12	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)		391,949	26.00
26.01	Sequestration adjustment (see instructions)		7,839	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		409,019	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)		-24,909	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: 14-1327 Component CCN: 14-8579	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/17/2024 11:02 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)		1,646,292	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		136,772	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,509,520	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		5,981	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)		5,981	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		252.39	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	225.78	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	225.78	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	3,878	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	875,575	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	875,575	16.00
16.01	Total program charges (see instructions)(from contractor's records)		568,596	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		15,187	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		23,387	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.)		619,564	16.04
16.05	Total program cost (see instructions)	0	642,951	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		77,733	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		94,984	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		642,951	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		82,089	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		725,040	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		725,040	26.00
26.01	Sequestration adjustment (see instructions)		14,501	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		629,397	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)		81,142	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: 14-1327 Component CCN: 14-8599	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/17/2024 11:02 am
	Title XVIII	RHC IV	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,764,526	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		95,119	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,669,407	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		7,289	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)		7,289	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		229.03	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	197.25	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	197.25	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,941	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	580,112	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	580,112	16.00
16.01	Total program charges (see instructions)(from contractor's records)		392,748	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		20,852	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		30,800	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.)		394,228	16.04
16.05	Total program cost (see instructions)	0	425,028	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		56,527	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		63,025	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		425,028	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		53,069	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		478,097	22.00
23.00	Allowable bad debts (see instructions)		501	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		326	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		478,423	26.00
26.01	Sequestration adjustment (see instructions)		9,568	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		415,071	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)		53,784	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: 14-1327 Component CCN: 14-8601	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/17/2024 11:02 am
	Title XVIII	RHC V	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,368,990	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		101,231	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,267,759	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,532	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		4,532	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		279.73	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	291.86	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	279.73	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,621	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	733,172	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	733,172	16.00
16.01	Total program charges (see instructions)(from contractor's records)		494,983	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		28,680	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		42,481	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.)		527,654	16.04
16.05	Total program cost (see instructions)	0	570,135	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		31,124	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		86,972	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		570,135	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		35,847	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		605,982	22.00
23.00	Allowable bad debts (see instructions)		112	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		73	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		606,055	26.00
26.01	Sequestration adjustment (see instructions)		12,121	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		435,599	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)		158,335	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: 14-1327 Component CCN: 14-8613	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/17/2024 11:02 am
	Title XVIII	RHC VI	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,086,791	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		90,183	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		996,608	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,749	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)		3,749	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		265.83	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	301.09	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	265.83	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,423	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	378,276	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	378,276	16.00
16.01	Total program charges (see instructions)(from contractor's records)		212,514	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		11,206	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		19,947	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.)		267,906	16.04
16.05	Total program cost (see instructions)	0	287,853	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		23,446	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		35,427	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		287,853	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		45,049	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		332,902	22.00
23.00	Allowable bad debts (see instructions)		189	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		123	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		333,025	26.00
26.01	Sequestration adjustment (see instructions)		6,661	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		279,919	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)		46,445	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: 14-1327 | Component CCN: 14-8568 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/17/2024 11:02 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)	2,247,069	2,247,069	2,247,069	2,247,069	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000261	0.000930	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	586	2,090	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	3,460	10,260	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4,046	12,350	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,307,730	2,307,730	2,307,730	2,307,730	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,283,122	1,283,122	1,283,122	1,283,122	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.001753	0.005352	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2,249	6,867	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6,295	19,217	0	0	10.00
11.00	Total number of injections/infusions (from your records)	16	57	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	393.44	337.14	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	12	37	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)	4,721	12,474	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)		25,512	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)		17,195	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1327 | Component CCN: 14-8579 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/17/2024 11:02 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)	1,004,423	1,004,423	1,004,423	1,004,423	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001555	0.016026	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,562	16,097	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	7,136	61,200	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	8,698	77,297	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,035,105	1,035,105	1,035,105	1,035,105	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	611,187	611,187	611,187	611,187	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.008403	0.074676	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	5,136	45,641	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	13,834	122,938	0	0	10.00
11.00	Total number of injections/infusions (from your records)	33	340	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	419.21	361.58	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	19	205	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)	7,965	74,124	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)		136,772	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)		82,089	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1327 | Component CCN: 14-8599 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/17/2024 11:02 am

Title XVIII | RHC IV | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	898,139	898,139	898,139	898,139	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000136	0.007945	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	122	7,136	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	865	42,120	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	987	49,256	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	932,049	932,049	932,049	932,049	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	832,477	832,477	832,477	832,477	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.001059	0.052847	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	882	43,994	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1,869	93,250	0	0	10.00
11.00	Total number of injections/infusions (from your records)	4	234	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	467.25	398.50	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	1	132	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)	467	52,602	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)		95,119	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)		53,069	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1327 | Component CCN: 14-8601 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/17/2024 11:02 am

Title XVIII | RHC V | 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)	592,282	592,282	592,282	592,282	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002155	0.009394	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,276	5,564	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	8,433	30,600	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	9,709	36,164	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	620,360	620,360	620,360	620,360	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	748,630	748,630	748,630	748,630	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.015651	0.058295	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	11,717	43,641	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	21,426	79,805	0	0	10.00
11.00	Total number of injections/infusions (from your records)	39	170	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	549.38	469.44	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	8	67	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)	4,395	31,452	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		101,231	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)		35,847	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1327 | Component CCN: 14-8613 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/17/2024 11:02 am

Title XVIII | RHC VI | 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)	430,730	430,730	430,730	430,730	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000048	0.009123	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	21	3,930	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	216	34,020	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	237	37,950	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	460,190	460,190	460,190	460,190	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	626,601	626,601	626,601	626,601	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000515	0.082466	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	323	51,673	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	560	89,623	0	0	10.00
11.00	Total number of injections/infusions (from your records)	1	189	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	560.00	474.20	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	95	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)	0	45,049	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)		90,183	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)		45,049	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1327 Component CCN: 14-8501	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/17/2024 11:02 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		52,876	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50		08/24/2023	5,485	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-5,485	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		47,391	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		16,769	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		64,160	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-1327 | Component CCN: 14-8568 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-5 | Date/Time Prepared: 5/17/2024 11:02 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		411,374	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50		08/24/2023	2,355	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)		-2,355	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		409,019	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		0	6.01
6.02	SETTLEMENT TO PROGRAM		24,909	6.02
7.00	Total Medicare program liability (see instructions)		384,110	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: 14-1327 Component CCN: 14-8579	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/17/2024 11:02 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		629,397	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		629,397	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		81,142	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		710,539	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: 14-1327 Component CCN: 14-8599	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/17/2024 11:02 am
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		415,071	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		415,071	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		53,784	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		468,855	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: 14-1327 Component CCN: 14-8601	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/17/2024 11:02 am
		RHC V	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		497,741	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50		08/24/2023	62,142	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)		-62,142	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		435,599	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		158,335	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		593,934	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: 14-1327 Component CCN: 14-8613	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/17/2024 11:02 am
		RHC VI	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		293,465	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50		08/24/2023	13,546	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)		-13,546	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		279,919	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		46,445	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		326,364	7.00

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