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: 14-1302	Period: From 10/01/2022 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/23/2024 11:09 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/23/2024 Time: 11:09 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 MIDWEST MEDICAL CENTER (14-1302) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 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	Tracy Bauer		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	Tracy Bauer			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	-35,503	-114,996	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER (OTHER)						4.00
5.00	SWING BED - SNF	0	130,524	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
10.00	RURAL HEALTH CLINIC I	0		142,444		0	10.00
10.01	RURAL HEALTH CLINIC II	0		5,692		0	10.01
200.00	TOTAL	0	95,021	33,140	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2024 11:09 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1 MEDICAL CENTER DRIVE	PO Box:			1.00
2.00	City: GALENA	State: IL	Zip Code: 61036-	County: JO DAVIESS	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	MIDWEST MEDICAL CENTER	141302	99914	1	02/01/2000	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	MIDWEST MEDICAL CENTER	14Z302	99914		02/01/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	GALENA STAUSS NURSING HOME	146140	99914		02/17/2010	N	P	N	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	MIDWEST HEALTH CLINIC	148511	99914		12/09/2010	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	MIDWEST HEALTH CLINIC OF ELIZABETH	148557	99914		07/15/2016	N	O	N	15.01
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)	10/01/2022	09/30/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2024 11:09 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2024 11:09 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2024 11:09 am

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2024 11:09 am

				1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)				
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?				68.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

			1.00	
	Long Term Care Hospital PPS			
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00
	TEFRA Providers			
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		Y	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2024 11:09 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	74,966	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.04	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	Y	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2024 11:09 am

		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	Y	Y	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/23/2024 11:09 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	02/19/2024	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/14/2023	Y	11/14/2023	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/23/2024 11:09 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.	Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	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.	DAVID	GOODMAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6082702962	DGOODMAN@WIPFLI.COM	43.00

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		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CPA		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: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 2/23/2024 11:09 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	16,472.00	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	16,472.00	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	16,472.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY	44.00	5	1,825		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	52	18,980			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
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		82				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: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2024 11:09 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)	500	32	786			1.00
2.00	HMO and other (see instructions)	101	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,183	0	1,445			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	143			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,683	32	2,374			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)	1,683	32	2,374	0.00	119.42	14.00
15.00	CAH visits	7,360	0	26,426			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		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	2.97	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			15,685	0.00	42.01	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	2,522	0	9,958	0.00	14.94	26.00
26.01	RURAL HEALTH CLINIC II	599	0	3,343	0.00	4.78	26.01
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	184.12	27.00
28.00	Observation Bed Days		0	243			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2024 11:09 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	141	16	199	1.00
2.00	HMO and other (see instructions)			28	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	141	16	199	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	0.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	0.00				53	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
26.25	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: 14-1302 | Component CCN: 14-8511 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/23/2024 11:09 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			ONE MEDICAL CENTER DRIVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	GALENA		IL	61036	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			07:30	17:00	07:30	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
				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: 14-1302
Component CCN: 14-8511

Period:
From 10/01/2022
To 09/30/2023

Worksheet S-8

Date/Time Prepared:
2/23/2024 11:09 am

RHC I | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		JO DAVIESS				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	07:30	17:00	07:30	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	07:30	17:00	08:00	12:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1302 | Component CCN: 14-8557 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/23/2024 11:09 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			560 PLEASANT STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ELIZABETH		IL	61028	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			07:30	17:00	07:30	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		JO DAVIESS				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	07:30	17:00	07:30	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1302
Component CCN: 14-8557

Period:
From 10/01/2022
To 09/30/2023

Worksheet S-8

Date/Time Prepared:
2/23/2024 11:09 am

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:30	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1302	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/23/2024 11:09 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)	0.632510	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,692,948	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	9,609,656	6.00
7.00	Medicaid cost (line 1 times line 6)	6,078,204	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	385,256	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)	385,256	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)	57,124	167,227	224,351	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	36,132	167,227	203,359	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)	36,132	167,227	203,359	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)	498,141	26.00
27.00	Medicare reimbursable bad debts (see instructions)	0	27.00
27.01	Medicare allowable bad debts (see instructions)	0	27.01
28.00	Non-Medicare bad debt amount (see instructions)	498,141	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	315,079	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	518,438	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	903,694	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1302	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/23/2024 11:09 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: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/23/2024 11:09 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		1,278,762	1,278,762	-1,273,363	5,399	1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG		0	0	52,816	52,816	1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL		0	0	2,403,009	2,403,009	1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB		0	0	0	0	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		854,233	854,233	-842,347	11,886	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO		0	0	1,024,349	1,024,349	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,788,961	3,788,961	-191,197	3,597,764	4.00
5.01	00570	ADMITTING	489,615	9,178	498,793	0	498,793	5.01
5.02	00550	INFORMATION TECHNOLOGY	345,111	479,923	825,034	0	825,034	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	453,739	453,739	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	835,786	2,271,288	3,107,074	-706,822	2,400,252	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	155,289	609,801	765,090	0	765,090	7.00
7.01	00701	OPERATION OF PLANT-SCC	98,666	215,450	314,116	0	314,116	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	88,180	88,180	0	88,180	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	32,813	32,813	0	32,813	8.01
9.00	00900	HOUSEKEEPING	238,607	46,176	284,783	0	284,783	9.00
9.01	00901	HOUSEKEEPING-SCC	92,634	22,051	114,685	0	114,685	9.01
10.00	01000	DIETARY	308,137	199,615	507,752	0	507,752	10.00
10.01	01001	DIETARY-SCC	333,861	291,345	625,206	86,311	711,517	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	395,838	10,870	406,708	0	406,708	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	116,226	16,065	132,291	0	132,291	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	252,565	19,879	272,444	0	272,444	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	525,962	45,131	571,093	0	571,093	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,129,322	130,236	1,259,558	117,722	1,377,280	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	14,805	14,805	44.00
46.00	04600	OTHER LONG TERM CARE	1,894,857	610,305	2,505,162	137,500	2,642,662	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	514,068	401,121	915,189	145,973	1,061,162	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	472,300	1,121,868	1,594,168	19,400	1,613,568	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	422,853	675,968	1,098,821	0	1,098,821	60.00
64.00	06400	INTRAVENOUS THERAPY	0	38,048	38,048	0	38,048	64.00
65.00	06500	RESPIRATORY THERAPY	103,797	63,401	167,198	-109,902	57,296	65.00
66.00	06600	PHYSICAL THERAPY	1,643,850	123,880	1,767,730	-42,372	1,725,358	66.00
66.01	06601	CARDIAC REHAB	0	0	0	144,277	144,277	66.01
67.00	06700	OCCUPATIONAL THERAPY	106,231	23,604	129,835	29,292	159,127	67.00
68.00	06800	SPEECH PATHOLOGY	90,839	8,584	99,423	0	99,423	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,079,335	1,079,335	0	1,079,335	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,772,203	1,772,203	0	1,772,203	73.00
76.00	03020	SLEEP LAB	947,415	72,369	1,019,784	-1,019,784	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,857,744	233,848	2,091,592	-51,479	2,040,113	88.00
88.01	08801	RURAL HEALTH CLINIC II	558,194	71,789	629,983	45,748	675,731	88.01
90.00	09000	CLINIC	0	841,024	841,024	917,278	1,758,302	90.00
91.00	09100	EMERGENCY	542,386	1,969,912	2,512,298	0	2,512,298	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,270,792	1,270,792	-1,270,792	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,472,153	20,788,008	35,260,161	84,161	35,344,322	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	27,399	27,399	-27,399	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	408,274	109,440	517,714	-69,842	447,872	194.01
194.02	07952	ADULT DAY CARE	0	0	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/23/2024 11:09 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	
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	13,080	13,080	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	14,880,427	20,924,847	35,805,274	0	35,805,274	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/23/2024 11:09 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	5,399		1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG	0	52,816		1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL	-55,121	2,347,888		1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB	0	0		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	11,886		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	-12,385	1,011,964		2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,597,764		4.00
5.01	00570	ADMITTING	0	498,793		5.01
5.02	00550	INFORMATION TECHNOLOGY	0	825,034		5.02
5.03	00590	HOSPITAL BILLING	-60,284	393,455		5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	-485,565	1,914,687		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	-8,090	757,000		7.00
7.01	00701	OPERATION OF PLANT-SCC	-12,350	301,766		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	88,180		8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	32,813		8.01
9.00	00900	HOUSEKEEPING	0	284,783		9.00
9.01	00901	HOUSEKEEPING-SCC	0	114,685		9.01
10.00	01000	DIETARY	-89,618	418,134		10.00
10.01	01001	DIETARY-SCC	-122,841	588,676		10.01
11.00	01100	CAFETERIA	0	0		11.00
11.01	01101	CAFETERIA-SCC	0	0		11.01
13.00	01300	NURSING ADMINISTRATION	0	406,708		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	132,291		14.00
15.00	01500	PHARMACY	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,099	271,345		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	571,093		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-17,537	1,359,743		30.00
42.00	04200	SUBPROVIDER	0	0		42.00
44.00	04400	SKILLED NURSING FACILITY	0	14,805		44.00
46.00	04600	OTHER LONG TERM CARE	-388,008	2,254,654		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-143,693	917,469		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-571,751	1,041,817		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	1,098,821		60.00
64.00	06400	INTRAVENOUS THERAPY	0	38,048		64.00
65.00	06500	RESPIRATORY THERAPY	0	57,296		65.00
66.00	06600	PHYSICAL THERAPY	-46,538	1,678,820		66.00
66.01	06601	CARDIAC REHAB	0	144,277		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	159,127		67.00
68.00	06800	SPEECH PATHOLOGY	0	99,423		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,079,335		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-974,871	797,332		73.00
76.00	03020	SLEEP LAB	0	0		76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0		76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-42,256	1,997,857		88.00
88.01	08801	RURAL HEALTH CLINIC II	-2,500	673,231		88.01
90.00	09000	CLINIC	-1,184,311	573,991		90.00
91.00	09100	EMERGENCY	-541,053	1,971,245		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	FAMILY PRACTICE	0	0		93.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,759,871	30,584,451		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	MIDWEST MEDICAL CLINIC	0	0		192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0		194.00
194.01	07951	ASSISTED LIVING UNITS	0	447,872		194.01
194.02	07952	ADULT DAY CARE	0	0		194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0		194.03
194.04	07954	IDLE SPACE	0	0		194.04

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
194.05	07955	COMMUNITY FITNESS CENTER	0	13,080		194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,759,871	31,045,403		200.00

RECLASSIFICATIONS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/23/2024 11:09 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS ADC AND ALU DIETARY EXPENSE				
1.00	DIETARY-SCC	10.01	0	86,311	1.00
	TOTALS		0	86,311	
	C - RECLASS ASSISTED LIVING BUILDING DEP				
1.00	NEW CAP REL COSTS-ALU BLDG	1.01	0	48,631	1.00
	TOTALS		0	48,631	
	D - RECLASS PT/MOB SPACE DEPRECIATION				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	27,399	1.00
	TOTALS		0	27,399	
	E - RECLASS NURSING HOME ADMIN AND GEN				
1.00	SKILLED NURSING FACILITY	44.00	0	14,805	1.00
2.00	OTHER LONG TERM CARE	46.00	0	153,969	2.00
	TOTALS		0	168,774	
	G - RECLASS PHYSICIAN HOSPITAL MED DIRCT				
1.00	ADULTS & PEDIATRICS	30.00	11,523	1,152	1.00
	TOTALS		11,523	1,152	
	H - RECLASS NEW HOSPITAL DEPRECIATION				
1.00	NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	1,259,877	1.00
	TOTALS		0	1,259,877	
	J - RECLASS NEW HOSPITAL MME DEPRECIATN				
1.00	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	0	843,973	1.00
	TOTALS		0	843,973	
	K - RECLASS INTEREST EXPENSE - NEW HOSP				
1.00	NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	1,087,189	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	0	164,203	2.00
	TOTALS		0	1,251,392	
	M - RECLASS PHYSICIAN IP ROUND TIME				
1.00	ADULTS & PEDIATRICS	30.00	16,617	2,493	1.00
2.00		0.00	0	0	2.00
	TOTALS		16,617	2,493	
	P - RECLASS PHYSICIAN BENEFITS				
1.00	RURAL HEALTH CLINIC	88.00	0	119,359	1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	36,407	2.00
	TOTALS		0	155,766	
	U - RECLASS COMMUNITY FITNESS CTR USE				
1.00	COMMUNITY FITNESS CENTER	194.05	12,310	770	1.00
2.00	OCCUPATIONAL THERAPY	67.00	27,668	1,624	2.00
	TOTALS		39,978	2,394	
	X - RECLASS SURGEON FEES				
1.00	OPERATING ROOM	50.00	0	137,937	1.00
	TOTALS		0	137,937	
	Y - RECLASS PROPERTY INSURANCE EXP				
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	85,673	1.00
	TOTALS		0	85,673	
	AA - RECLASS CLINIC MGR TIME TO HOSP/NH				
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	1,364	0	1.00
2.00	RURAL HEALTH CLINIC II	88.01	10,913	0	2.00
	TOTALS		12,277	0	
	BB - RECLASS SR CARE ADMINISTRATOR TIME				
1.00	ASSISTED LIVING UNITS	194.01	16,469	0	1.00
	TOTALS		16,469	0	
	FF - RECLASS EXPENSES TO MATCH REVENUES				
1.00		0.00	0	0	1.00
	TOTALS		0	0	
	HH - RECLASS HOSP MED DIRECTOR TIME				
1.00	ADULTS & PEDIATRICS	30.00	75,591	10,346	1.00
2.00	CARDIAC REHAB	66.01	30,237	4,138	2.00
	TOTALS		105,828	14,484	
	JJ - RECLASS CAP LEASE INTEREST EXPENSE				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	19,400	1.00
	TOTALS		0	19,400	
	MM - RECLASS CLINIC MD SALARY				
1.00		0.00	0	0	1.00
	TOTALS		0	0	
	NN - ENT MD TIME IN OR				
1.00		0.00	0	0	1.00
	TOTALS		0	0	

RECLASSIFICATIONS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/23/2024 11:09 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	PP - RECLASS HOSPITAL BILLING EXPENSES					
1.00	HOSPITAL BILLING	5.03	0	453,739		1.00
	TOTALS		0	453,739		
	QQ - RECLASS CARDIAC REHAB EXP					
1.00	CARDIAC REHAB	66.01	103,797	6,105		1.00
	TOTALS		103,797	6,105		
	SS - RECLASS PHYSICIAN SURGERY TIME					
1.00	OPERATING ROOM	50.00	5,756	2,280		1.00
	TOTALS		5,756	2,280		
	TT - RECLASS SPECIALTY CLINIC EXPENSES					
1.00	CLINIC	90.00	947,415	72,369		1.00
2.00	CLINIC	90.00	0	35,431		2.00
	TOTALS		947,415	107,800		
500.00	Grand Total: Increases		1,259,660	4,675,580		500.00

RECLASSIFICATIONS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/23/2024 11:09 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS ADC AND ALU DIETARY EXPENSE						
1.00	ASSISTED LIVING UNITS	194.01	0	86,311	0		1.00
	TOTALS		0	86,311			
	C - RECLASS ASSISTED LIVING BUILDING DEP						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	48,631	9		1.00
	TOTALS		0	48,631			
	D - RECLASS PT/MOB SPACE DEPRECIATION						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	27,399	9		1.00
	TOTALS		0	27,399			
	E - RECLASS NURSING HOME ADMIN AND GEN						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	168,774	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	168,774			
	G - RECLASS PHYSICIAN HOSPITAL MED DIRCT						
1.00	RURAL HEALTH CLINIC	88.00	11,523	1,152	0		1.00
	TOTALS		11,523	1,152			
	H - RECLASS NEW HOSPITAL DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,259,877	9		1.00
	TOTALS		0	1,259,877			
	J - RECLASS NEW HOSPITAL MME DEPRECIATN						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	843,973	9		1.00
	TOTALS		0	843,973			
	K - RECLASS INTEREST EXPENSE - NEW HOSP						
1.00	INTEREST EXPENSE	113.00	0	1,251,392	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	1,251,392			
	M - RECLASS PHYSICIAN IP ROUND TIME						
1.00	RURAL HEALTH CLINIC	88.00	15,250	2,288	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	1,367	205	0		2.00
	TOTALS		16,617	2,493			
	P - RECLASS PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	155,766	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	155,766			
	U - RECLASS COMMUNITY FITNESS CTR USE						
1.00	PHYSICAL THERAPY	66.00	39,978	2,394	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		39,978	2,394			
	X - RECLASS SURGEON FEES						
1.00	CLINIC	90.00	0	137,937	0		1.00
	TOTALS		0	137,937			
	Y - RECLASS PROPERTY INSURANCE EXP						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	85,673	12		1.00
	TOTALS		0	85,673			
	AA - RECLASS CLINIC MGR TIME TO HOSP/NH						
1.00	RURAL HEALTH CLINIC	88.00	12,277	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		12,277	0			
	BB - RECLASS SR CARE ADMINISTRATOR TIME						
1.00	OTHER LONG TERM CARE	46.00	16,469	0	0		1.00
	TOTALS		16,469	0			
	FF - RECLASS EXPENSES TO MATCH REVENUES						
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
	HH - RECLASS HOSP MED DIRECTOR TIME						
1.00	RURAL HEALTH CLINIC	88.00	105,828	14,484	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		105,828	14,484			
	JJ - RECLASS CAP LEASE INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	19,400	0		1.00
	TOTALS		0	19,400			
	MM - RECLASS CLINIC MD SALARY						
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
	NN - ENT MD TIME IN OR						
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			

RECLASSIFICATIONS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/23/2024 11:09 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	PP - RECLASS HOSPITAL BILLING EXPENSES						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	453,739	0		1.00
	TOTALS		0	453,739			
	QQ - RECLASS CARDIAC REHAB EXP						
1.00	RESPIRATORY THERAPY	65.00	103,797	6,105	0		1.00
	TOTALS		103,797	6,105			
	SS - RECLASS PHYSICIAN SURGERY TIME						
1.00	RURAL HEALTH CLINIC	88.00	5,756	2,280	0		1.00
	TOTALS		5,756	2,280			
	TT - RECLASS SPECIALTY CLINIC EXPENSES						
1.00	SLEEP LAB	76.00	947,415	72,369	0		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35,431	0		2.00
	TOTALS		947,415	107,800			
500.00	Grand Total: Decreases		1,259,660	4,675,580			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 2/23/2024 11:09 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	448,597	0	0	0	0	1.00
2.00	Land Improvements	4,011,958	0	0	0	0	2.00
3.00	Buildings and Fixtures	38,884,414	207,680	0	207,680	9,725	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	8,694,652	1,404,049	0	1,404,049	352,013	6.00
7.00	HIT designated Assets	2,805,803	25,795	0	25,795	58,745	7.00
8.00	Subtotal (sum of lines 1-7)	54,845,424	1,637,524	0	1,637,524	420,483	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	54,845,424	1,637,524	0	1,637,524	420,483	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	448,597	0	1.00
2.00	Land Improvements	4,011,958	0	2.00
3.00	Buildings and Fixtures	39,082,369	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	9,746,688	0	6.00
7.00	HIT designated Assets	2,772,853	0	7.00
8.00	Subtotal (sum of lines 1-7)	56,062,465	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	56,062,465	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 2/23/2024 11:09 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	1,278,762	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0	0	0	0	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	854,233	0	0	0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,132,995	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,278,762		1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	0		1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0		1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0		1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	854,233		2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0		2.01
3.00	Total (sum of lines 1-2)	0	2,132,995		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 2/23/2024 11:09 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,895,156	0	4,895,156	0.090408	7,746	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	2,644,777	0	2,644,777	0.048846	4,185	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	35,356,441	0	35,356,441	0.652990	55,943	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0.000000	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,027,734	0	1,027,734	0.018981	1,626	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	10,472,720	251,408	10,221,312	0.188775	16,173	2.01
3.00	Total (sum of lines 1-2)	54,396,828	251,408	54,145,420	1.000000	85,673	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	7,746	-2,347	0	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	0	4,185	48,631	0	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0	55,943	1,259,877	0	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	1,626	10,260	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0	16,173	843,549	0	2.01
3.00	Total (sum of lines 1-2)	0	0	85,673	2,159,970	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	7,746	0	0	5,399	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	4,185	0	0	52,816	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	1,032,068	55,943	0	0	2,347,888	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,626	0	0	11,886	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	152,242	16,173	0	0	1,011,964	2.01
3.00	Total (sum of lines 1-2)	1,184,310	85,673	0	0	3,429,953	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/23/2024 11:09 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
1.01	Investment income - NEW CAP REL COSTS-ALU BLDG (chapter 2)		0	NEW CAP REL COSTS-ALU BLDG	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-2007 HOSPITAL (chapter 2)	B	-79,191	NEW CAP REL COSTS-2007 HOSPITAL	1.02	11	1.02
1.03	Investment income - NEW CAP REL COSTS-2007 MOB (chapter 2)		0	NEW CAP REL COSTS-2007 MOB	1.03	0	1.03
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - NEW CAP REL COSTS-MVBLE EQUIP NEW HO (chapter 2)	B	-11,961	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	11	2.01
3.00	Investment income - other (chapter 2)	B	-1,413	RADIOLOGY-DIAGNOSTIC	54.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-6,090	OPERATION OF PLANT	7.00	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	-2,456,932			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	-89,618	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,099	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/23/2024 11:09 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	
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-ALU BLDG		0	NEW CAP REL COSTS-ALU BLDG	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-2007 HOSPITAL		0	NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	26.02
26.03	Depreciation - NEW CAP REL COSTS-2007 MOB		0	NEW CAP REL COSTS-2007 MOB	1.03	0	26.03
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP NEW HO		0	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	0	27.01
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	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-424	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	9	32.00
33.00	NURSING HOME RENTAL INCOME	B	-12,350	OPERATION OF PLANT-SCC	7.01	0	33.00
33.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.01
33.05	PROVIDER RHC REVENUE	B	-12,634	RURAL HEALTH CLINIC	88.00	0	33.05
33.06	PART B BILLING COSTS	A	-60,284	HOSPITAL BILLING	5.03	0	33.06
33.07	SCHOOL ATHLETIC TRAINING REVENUE	B	-46,538	PHYSICAL THERAPY	66.00	0	33.07
33.08	HOSPITAL BED ASSESS (UP TO PAID AMT)	A	-371,601	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.08
33.09	MARKETING EXPENSES - NONALLOW	A	-80,332	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.09
34.00	LOBBYING EXPENSE ON DUES PAID	A	-30,090	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	34.00
35.00	COMMMUNITY GRANTS / DONATIONS / PROM	A	-3,542	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	35.00
36.00	NH BED ASSESSMENT	A	-365,260	OTHER LONG TERM CARE	46.00	0	36.00
37.00	AR INSURANCE REVENUE	B	-20,239	OTHER LONG TERM CARE	46.00	0	37.00
38.00	MISC CLINIC REVENUE	B	-2,500	RURAL HEALTH CLINIC II	88.01	0	38.00
40.00	SENIOR CARE CAMPUS CAFETERIA	B	-36,604	DIETARY-SCC	10.01	0	40.00
41.00	OFFSET INTERNAL ALLOCATION FOR ADC/A	B	-86,237	DIETARY-SCC	10.01	0	41.00
42.00	RHC PROVIDER OR TIME	A	-29,622	RURAL HEALTH CLINIC	88.00	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.00
43.01	PHARMACY CONTRACT PROG EXPENSE	A	-974,871	DRUGS CHARGED TO PATIENTS	73.00	0	43.01
43.02	SLEEP MISC REVENUE	B	-2,000	OPERATION OF PLANT	7.00	0	43.02
43.03	LAPSE CY PORT OF ADV REFUND 2006	A	24,070	NEW CAP REL COSTS-2007 HOSPITAL	1.02	11	43.03
43.04	NH MISC REVENUE	B	-2,509	OTHER LONG TERM CARE	46.00	0	43.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,759,871				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: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 2/23/2024 11:09 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	91.00	EMERGENCY	1,804,110	541,053	1,263,057	0	0	1.00
2.00	60.00	LABORATORY	12,083	0	12,083	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	570,338	570,338	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	17,537	17,537	0	0	0	4.00
5.00	50.00	OPERATING ROOM	143,693	143,693	0	0	0	5.00
6.00	90.00	CLINIC	1,184,311	1,184,311	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,732,072	2,456,932	1,275,140		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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	541,053		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	570,338		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	17,537		4.00
5.00	50.00	OPERATING ROOM	0	0	0	143,693		5.00
6.00	90.00	CLINIC	0	0	0	1,184,311		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,456,932		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/23/2024 11:09 am

		Occupational Therapy	Cost
			1.00
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	10	1.00
2.00	Line 1 multiplied by 15 hours per week	150	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	22	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	6.47	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	148.75	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	91.21	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	45.61	45.61	0.00			11.00
12.00	Number of travel hours (provider site)	0	43	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	13,567	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	13,567	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	13,567	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	91.21	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	13,682	22.00
23.00	Total salary equivalency (see instructions)	13,682	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	1,003	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	1,003	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	142	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	1,145	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	3,922	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	3,922	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	1,145	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/23/2024 11:09 am

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	91.21	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	13,682		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	1,145		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	14,827		63.00
64.00	Total cost of outside supplier services (from your records)	13,039		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	1,003		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	142		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	1,145		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	142		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	3,922		101.01
101.02	Line 34 = sum of lines 27 and 31	4,064		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	3,922		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	3,922		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	5,399	5,399				1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG	52,816	0	52,816			1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL	2,347,888	0	0	2,347,888		1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	11,886					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	1,011,964					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,597,764	0	0	0	0	4.00
5.01	00570	ADMITTING	498,793	0	0	33,934	0	5.01
5.02	00550	INFORMATION TECHNOLOGY	825,034	61	0	16,855	0	5.02
5.03	00590	HOSPITAL BILLING	393,455	0	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	1,914,687	894	15,879	203,652	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	757,000	0	0	157,927	0	7.00
7.01	00701	OPERATION OF PLANT-SCC	301,766	206	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	88,180	0	0	15,959	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	32,813	21	0	0	0	8.01
9.00	00900	HOUSEKEEPING	284,783	0	0	12,103	0	9.00
9.01	00901	HOUSEKEEPING-SCC	114,685	39	0	0	0	9.01
10.00	01000	DIETARY	418,134	0	0	143,717	0	10.00
10.01	01001	DIETARY-SCC	588,676	152	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	406,708	68	0	5,738	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	132,291	0	0	30,572	0	14.00
15.00	01500	PHARMACY	0	0	0	34,652	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	271,345	0	0	30,797	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	571,093	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,359,743	0	0	396,724	0	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	14,805	178	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	2,254,654	1,857	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	917,469	0	0	241,352	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,421	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,041,817	0	0	162,769	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,098,821	0	0	48,234	0	60.00
64.00	06400	INTRAVENOUS THERAPY	38,048	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	57,296	0	0	8,428	0	65.00
66.00	06600	PHYSICAL THERAPY	1,678,820	0	0	193,879	0	66.00
66.01	06601	CARDIAC REHAB	144,277	0	0	13,448	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	159,127	0	0	16,676	0	67.00
68.00	06800	SPEECH PATHOLOGY	99,423	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,079,335	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	797,332	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,997,857	0	0	256,996	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	673,231	0	0	0	0	88.01
90.00	09000	CLINIC	573,991	0	0	44,828	0	90.00
91.00	09100	EMERGENCY	1,971,245	0	0	248,389	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,584,451	3,476	15,879	2,320,050	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	13,314	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	447,872	0	34,171	0	0	194.01

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB	
			0	1.00	1.01	1.02	1.03	
194.02	07952	ADULT DAY CARE	0	0	2,766	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	1,923	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	13,080	0	0	14,524	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	31,045,403	5,399	52,816	2,347,888	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	INFORMATION TECHNOLOGY	
			2.00	2.01	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	11,886					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	1,011,964				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	3,597,764			4.00
5.01	00570	ADMITTING	0	0	139,397	672,124		5.01
5.02	00550	INFORMATION TECHNOLOGY	0	75,330	98,256	0	1,015,536	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	1,004	115,824	238,342	0	150,447	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	34,880	44,212	0	28,209	7.00
7.01	00701	OPERATION OF PLANT-SCC	301	0	28,091	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	506	0	0	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	294	67,933	0	0	9.00
9.01	00901	HOUSEKEEPING-SCC	0	0	26,374	0	0	9.01
10.00	01000	DIETARY	0	28,463	87,729	0	18,806	10.00
10.01	01001	DIETARY-SCC	0	0	95,053	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	0	112,698	0	4,702	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	33,090	0	0	14.00
15.00	01500	PHARMACY	0	1,760	0	0	14,105	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	122	71,907	0	18,806	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	149,745	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	54,090	321,526	65,582	94,031	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	8,740	0	534,788	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	327,945	147,998	107,927	89,330	50.00
53.00	05300	ANESTHESIOLOGY	0	20,149	0	23,833	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	256,905	134,467	133,174	56,419	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	21,251	120,389	80,451	23,508	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	15,919	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,296	0	1,127	0	65.00
66.00	06600	PHYSICAL THERAPY	0	10,831	456,634	74,976	141,047	66.00
66.01	06601	CARDIAC REHAB	0	8,545	38,160	4,084	14,105	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	38,122	6,691	4,702	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	25,862	4,225	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	36,969	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	59,970	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14	8,466	170,275	0	150,450	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,521	63,150	0	51,717	88.01
90.00	09000	CLINIC	0	8,456	74,713	0	65,822	90.00
91.00	09100	EMERGENCY	0	21,605	154,421	57,196	56,419	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,059	1,002,239	3,473,332	672,124	982,625	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	102	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	1,140	7,913	120,927	0	0	194.01
194.02	07952	ADULT DAY CARE	687	0	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	INFORMATION TECHNOLOGY	
			NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
			2.00	2.01	4.00	5.01	5.02	
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	1,710	3,505	0	32,911	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,886	1,011,964	3,597,764	672,124	1,015,536	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	HOSPITAL BILLING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.03	5A.03	5.04	6.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING	393,455					5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	0	2,640,729	2,640,729			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	1,022,228	113,488	0	1,135,716	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	330,364	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	104,645	11,618	0	9,364	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	32,834	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	365,113	40,535	0	7,102	9.00
9.01	00901	HOUSEKEEPING-SCC	0	141,098	0	0	0	9.01
10.00	01000	DIETARY	0	696,849	77,364	0	84,330	10.00
10.01	01001	DIETARY-SCC	0	683,881	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	529,914	58,831	0	3,367	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	195,953	21,755	0	17,939	14.00
15.00	01500	PHARMACY	0	50,517	5,608	0	20,333	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	392,977	43,628	0	18,071	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	720,838	80,027	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,641	2,327,337	258,381	0	232,789	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	14,983	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	2,800,039	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	58,653	1,890,674	209,903	0	141,619	50.00
53.00	05300	ANESTHESIOLOGY	12,952	59,355	6,590	0	1,420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,391	1,857,942	206,269	0	95,509	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	43,722	1,436,376	159,466	0	28,303	60.00
64.00	06400	INTRAVENOUS THERAPY	8,651	62,618	6,952	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	612	72,759	8,078	0	4,945	65.00
66.00	06600	PHYSICAL THERAPY	40,746	2,596,933	288,312	0	122,970	66.00
66.01	06601	CARDIAC REHAB	2,219	224,838	24,962	0	7,891	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,636	228,954	25,418	0	9,785	67.00
68.00	06800	SPEECH PATHOLOGY	2,296	131,806	14,633	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,091	1,136,395	126,163	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,591	889,893	98,796	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	20,129	2,604,187	289,123	0	150,799	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,174	795,793	88,349	0	0	88.01
90.00	09000	CLINIC	1,868	769,678	85,450	0	17,097	90.00
91.00	09100	EMERGENCY	31,083	2,540,358	282,031	0	145,749	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	393,455	30,348,858	2,631,730	0	1,119,382	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,416	1,489	0	7,812	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	612,023	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	3,453	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	1,923	213	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	65,730	7,297	0	8,522	194.05

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/23/2024 11:09 am

	Cost Center Description	HOSPITAL BILLING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		5.03	5A.03	5.04	6.00	7.00	
200.00	Cross Foot Adjustments		0				200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	393,455	31,045,403	2,640,729	0	1,135,716	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-SCC	
			7.01	8.00	8.01	9.00	9.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC	330,364					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	125,627				8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	1,042	0	33,876			8.01
9.00	00900	HOUSEKEEPING	0	0	0	412,750		9.00
9.01	00901	HOUSEKEEPING-SCC	1,981	0	0	0	143,079	9.01
10.00	01000	DIETARY	0	0	0	34,070	0	10.00
10.01	01001	DIETARY-SCC	7,699	0	0	0	4,889	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	3,452	0	0	1,360	2,192	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	7,248	0	14.00
15.00	01500	PHARMACY	0	0	0	8,215	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	7,301	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	125,627	0	94,047	0	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	9,036	0	0	0	5,737	44.00
46.00	04600	OTHER LONG TERM CARE	94,005	0	33,876	0	59,686	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	57,215	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	574	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38,586	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	11,435	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,998	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	18,108	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	1,860	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,435	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	62,784	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	6,376	0	90.00
91.00	09100	EMERGENCY	0	0	0	58,884	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	117,215	125,627	33,876	411,496	72,504	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	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	102,833	0	0	0	65,291	194.01
194.02	07952	ADULT DAY CARE	8,322	0	0	0	5,284	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	101,994	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	1,254	0	194.05

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/23/2024 11:09 am

	Cost Center Description	OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-SCC	
		7.01	8.00	8.01	9.00	9.01	
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)	330,364	125,627	33,876	412,750	143,079	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	DIETARY	DIETARY-SCC	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	
			10.00	10.01	11.00	11.01	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING-SCC						9.01
10.00	01000	DIETARY	892,613					10.00
10.01	01001	DIETARY-SCC	0	696,469				10.01
11.00	01100	CAFETERIA	0	0	0			11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0		11.01
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	599,116	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	892,613	0	0	0	334,079	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	446,356	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	130,595	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	134,442	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	892,613	446,356	0	0	599,116	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	250,113	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	0	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.05

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/23/2024 11:09 am

	Cost Center Description	DIETARY	DIETARY-SCC	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	
		10.00	10.01	11.00	11.01	13.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	892,613	696,469	0	0	599,116	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			14.00	15.00	16.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING-SCC						9.01
10.00	01000	DIETARY						10.00
10.01	01001	DIETARY-SCC						10.01
11.00	01100	CAFETERIA						11.00
11.01	01101	CAFETERIA-SCC						11.01
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	242,895					14.00
15.00	01500	PHARMACY	0	84,673				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,001	0	462,978			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	800,865		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,188	0	41,942	0	4,315,003	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	29,756	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	3,433,962	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,078	0	69,023	0	2,528,107	50.00
53.00	05300	ANESTHESIOLOGY	3,439	0	15,242	800,865	887,485	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,452	0	85,150	0	2,288,908	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	51,451	0	1,687,031	60.00
64.00	06400	INTRAVENOUS THERAPY	4,949	0	10,181	0	84,700	64.00
65.00	06500	RESPIRATORY THERAPY	5,641	0	721	0	94,142	65.00
66.00	06600	PHYSICAL THERAPY	9,960	0	47,949	0	3,084,232	66.00
66.01	06601	CARDIAC REHAB	0	0	2,612	0	262,163	66.01
67.00	06700	OCCUPATIONAL THERAPY	679	0	4,279	0	270,550	67.00
68.00	06800	SPEECH PATHOLOGY	262	0	2,702	0	149,403	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	140,387	0	23,643	0	1,426,588	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49	84,673	38,353	0	1,111,764	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,626	0	23,687	0	3,141,206	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,332	0	7,266	0	894,740	88.01
90.00	09000	CLINIC	10,061	0	2,198	0	890,860	90.00
91.00	09100	EMERGENCY	9,791	0	36,579	0	3,207,834	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	242,895	84,673	462,978	800,865	29,788,434	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	22,717	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	0	0	1,030,260	194.01
194.02	07952	ADULT DAY CARE	0	0	0	0	17,059	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	104,130	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	0	82,803	194.05

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/23/2024 11:09 am

	Cost Center Description	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
		14.00	15.00	16.00	19.00	24.00	
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	242,895	84,673	462,978	800,865	31,045,403	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG				1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL				1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB				1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00550	INFORMATION TECHNOLOGY				5.02
5.03	00590	HOSPITAL BILLING				5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT-SCC				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC				8.01
9.00	00900	HOUSEKEEPING				9.00
9.01	00901	HOUSEKEEPING-SCC				9.01
10.00	01000	DIETARY				10.00
10.01	01001	DIETARY-SCC				10.01
11.00	01100	CAFETERIA				11.00
11.01	01101	CAFETERIA-SCC				11.01
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	4,315,003		30.00
42.00	04200	SUBPROVIDER	0	0		42.00
44.00	04400	SKILLED NURSING FACILITY	0	29,756		44.00
46.00	04600	OTHER LONG TERM CARE	0	3,433,962		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,528,107		50.00
53.00	05300	ANESTHESIOLOGY	0	887,485		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,288,908		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	1,687,031		60.00
64.00	06400	INTRAVENOUS THERAPY	0	84,700		64.00
65.00	06500	RESPIRATORY THERAPY	0	94,142		65.00
66.00	06600	PHYSICAL THERAPY	0	3,084,232		66.00
66.01	06601	CARDIAC REHAB	0	262,163		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	270,550		67.00
68.00	06800	SPEECH PATHOLOGY	0	149,403		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,426,588		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,111,764		73.00
76.00	03020	SLEEP LAB	0	0		76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0		76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	3,141,206		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	894,740		88.01
90.00	09000	CLINIC	0	890,860		90.00
91.00	09100	EMERGENCY	0	3,207,834		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	04040	FAMILY PRACTICE	0	0		93.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	29,788,434		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,717		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0		192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0		194.00
194.01	07951	ASSISTED LIVING UNITS	0	1,030,260		194.01
194.02	07952	ADULT DAY CARE	0	17,059		194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0		194.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
194.04	07954	IDLE SPACE	0	104,130		194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	82,803		194.05
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	31,045,403		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00570	ADMITTING	0	0	0	33,934	0	5.01
5.02	00550	INFORMATION TECHNOLOGY	0	61	0	16,855	0	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	0	894	15,879	203,652	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	157,927	0	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	206	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	15,959	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	21	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	0	0	12,103	0	9.00
9.01	00901	HOUSEKEEPING-SCC	0	39	0	0	0	9.01
10.00	01000	DIETARY	0	0	0	143,717	0	10.00
10.01	01001	DIETARY-SCC	0	152	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	68	0	5,738	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	30,572	0	14.00
15.00	01500	PHARMACY	0	0	0	34,652	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	30,797	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	396,724	0	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	178	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	1,857	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	241,352	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,421	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,169	0	0	162,769	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	48,234	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,428	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	193,879	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	13,448	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	16,676	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	256,996	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	44,828	0	90.00
91.00	09100	EMERGENCY	0	0	0	248,389	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,169	3,476	15,879	2,320,050	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	13,314	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	34,171	0	0	194.01
194.02	07952	ADULT DAY CARE	0	0	2,766	0	0	194.02

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB	
			0	1.00	1.01	1.02	1.03	
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	1,923	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	14,524	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,169	5,399	52,816	2,347,888	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
			2.00	2.01	2A	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0		4.00
5.01	00570	ADMITTING	0	0	33,934	0	33,934	5.01
5.02	00550	INFORMATION TECHNOLOGY	0	75,330	92,246	0	0	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	1,004	115,824	337,253	0	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	34,880	192,807	0	0	7.00
7.01	00701	OPERATION OF PLANT-SCC	301	0	507	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	506	16,465	0	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	21	0	0	8.01
9.00	00900	HOUSEKEEPING	0	294	12,397	0	0	9.00
9.01	00901	HOUSEKEEPING-SCC	0	0	39	0	0	9.01
10.00	01000	DIETARY	0	28,463	172,180	0	0	10.00
10.01	01001	DIETARY-SCC	0	0	152	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	0	5,806	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	30,572	0	0	14.00
15.00	01500	PHARMACY	0	1,760	36,412	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	122	30,919	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	54,090	450,814	0	3,312	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	178	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	8,740	0	10,597	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	327,945	569,297	0	5,450	50.00
53.00	05300	ANESTHESIOLOGY	0	20,149	22,570	0	1,204	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	256,905	420,843	0	6,718	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	21,251	69,485	0	4,063	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	804	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,296	13,724	0	57	65.00
66.00	06600	PHYSICAL THERAPY	0	10,831	204,710	0	3,786	66.00
66.01	06601	CARDIAC REHAB	0	8,545	21,993	0	206	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	16,676	0	338	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	213	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,867	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,028	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14	8,466	265,476	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,521	1,521	0	0	88.01
90.00	09000	CLINIC	0	8,456	53,284	0	0	90.00
91.00	09100	EMERGENCY	0	21,605	269,994	0	2,888	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,059	1,002,239	3,352,872	0	33,934	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	102	13,416	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	1,140	7,913	43,224	0	0	194.01
194.02	07952	ADULT DAY CARE	687	0	3,453	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
			2.00	2.01	2A	4.00	5.01	
194.04	07954	IDLE SPACE	0	0	1,923	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	1,710	16,234	0	0	194.05
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)	11,886	1,011,964	3,431,122	0	33,934	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	INFORMATION TECHNOLOGY	HOSPITAL BILLING	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.02	5.03	5.04	6.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY	92,246					5.02
5.03	00590	HOSPITAL BILLING	0	0				5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	13,668	0	350,921			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	2,562	0	15,081	0	210,450	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,544	0	1,735	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	0	5,387	0	1,316	9.00
9.01	00901	HOUSEKEEPING-SCC	0	0	0	0	0	9.01
10.00	01000	DIETARY	1,708	0	10,281	0	15,626	10.00
10.01	01001	DIETARY-SCC	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	427	0	7,818	0	624	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	2,891	0	3,324	14.00
15.00	01500	PHARMACY	1,281	0	745	0	3,768	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,708	0	5,798	0	3,349	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	10,635	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,541	0	34,335	0	43,136	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,114	0	27,893	0	26,242	50.00
53.00	05300	ANESTHESIOLOGY	0	0	876	0	263	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,125	0	27,410	0	17,698	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,135	0	21,191	0	5,245	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	924	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,073	0	916	65.00
66.00	06600	PHYSICAL THERAPY	12,812	0	38,313	0	22,787	66.00
66.01	06601	CARDIAC REHAB	1,281	0	3,317	0	1,462	66.01
67.00	06700	OCCUPATIONAL THERAPY	427	0	3,378	0	1,813	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,945	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	16,765	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	13,129	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,666	0	38,423	0	27,943	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,698	0	11,740	0	0	88.01
90.00	09000	CLINIC	5,979	0	11,355	0	3,168	90.00
91.00	09100	EMERGENCY	5,125	0	37,478	0	27,008	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	89,257	0	349,725	0	207,423	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	198	0	1,448	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	0	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	28	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	2,989	0	970	0	1,579	194.05

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/23/2024 11:09 am

	Cost Center Description	INFORMATION TECHNOLOGY	HOSPITAL BILLING	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		5.02	5.03	5.04	6.00	7.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	92,246	0	350,921	0	210,450	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-SCC	
			7.01	8.00	8.01	9.00	9.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC	507					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,744				8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	2	0	23			8.01
9.00	00900	HOUSEKEEPING	0	0	0	19,100		9.00
9.01	00901	HOUSEKEEPING-SCC	3	0	0	0	42	9.01
10.00	01000	DIETARY	0	0	0	1,577	0	10.00
10.01	01001	DIETARY-SCC	12	0	0	0	1	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	5	0	0	63	1	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	335	0	14.00
15.00	01500	PHARMACY	0	0	0	380	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	338	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	19,744	0	4,352	0	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	14	0	0	0	2	44.00
46.00	04600	OTHER LONG TERM CARE	144	0	23	0	18	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	2,648	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	27	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,786	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	529	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	92	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	838	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	86	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	66	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,905	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	295	0	90.00
91.00	09100	EMERGENCY	0	0	0	2,725	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	180	19,744	23	19,042	22	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	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	157	0	0	0	18	194.01
194.02	07952	ADULT DAY CARE	13	0	0	0	2	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	157	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	58	0	194.05

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/23/2024 11:09 am

	Cost Center Description	OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-SCC	
		7.01	8.00	8.01	9.00	9.01	
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)	507	19,744	23	19,100	42	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	DIETARY	DIETARY-SCC	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	
			10.00	10.01	11.00	11.01	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING-SCC						9.01
10.00	01000	DIETARY	201,372					10.00
10.01	01001	DIETARY-SCC	0	165				10.01
11.00	01100	CAFETERIA	0	0	0			11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0		11.01
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	14,744	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	201,372	0	0	0	8,221	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	106	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	3,214	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	3,309	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	201,372	106	0	0	14,744	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	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	59	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	0	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.05

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/23/2024 11:09 am

	Cost Center Description	DIETARY	DIETARY-SCC	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	
		10.00	10.01	11.00	11.01	13.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	201,372	165	0	0	14,744	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			14.00	15.00	16.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING-SCC						9.01
10.00	01000	DIETARY						10.00
10.01	01001	DIETARY-SCC						10.01
11.00	01100	CAFETERIA						11.00
11.01	01101	CAFETERIA-SCC						11.01
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	37,122					14.00
15.00	01500	PHARMACY	0	42,586				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	153	0	42,265			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	10,635		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,251	0	3,828		778,906	30.00
42.00	04200	SUBPROVIDER	0	0	0		0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		194	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		10,888	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,444	0	6,300		653,602	50.00
53.00	05300	ANESTHESIOLOGY	526	0	1,391		26,857	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	833	0	7,780		488,193	54.00
57.00	05700	CT SCAN	0	0	0		0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		0	58.00
60.00	06000	LABORATORY	0	0	4,696		107,344	60.00
64.00	06400	INTRAVENOUS THERAPY	756	0	929		3,413	64.00
65.00	06500	RESPIRATORY THERAPY	862	0	66		16,790	65.00
66.00	06600	PHYSICAL THERAPY	1,522	0	4,376		289,144	66.00
66.01	06601	CARDIAC REHAB	0	0	238		28,583	66.01
67.00	06700	OCCUPATIONAL THERAPY	104	0	391		23,193	67.00
68.00	06800	SPEECH PATHOLOGY	40	0	247		2,445	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,456	0	2,158		42,246	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8	42,586	3,500		62,251	73.00
76.00	03020	SLEEP LAB	0	0	0		0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0		0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0		0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,624	0	2,162		352,199	88.00
88.01	08801	RURAL HEALTH CLINIC II	509	0	663		19,131	88.01
90.00	09000	CLINIC	1,538	0	201		75,820	90.00
91.00	09100	EMERGENCY	1,496	0	3,339		353,362	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0		0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,122	42,586	42,265	0	3,334,561	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		15,062	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0		0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0		0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	0		43,458	194.01
194.02	07952	ADULT DAY CARE	0	0	0		3,468	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0		0	194.03
194.04	07954	IDLE SPACE	0	0	0		2,108	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0		21,830	194.05

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/23/2024 11:09 am

	Cost Center Description	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
		14.00	15.00	16.00	19.00	24.00	
200.00	Cross Foot Adjustments				10,635	10,635	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	37,122	42,586	42,265	10,635	3,431,122	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG				1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL				1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB				1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00550	INFORMATION TECHNOLOGY				5.02
5.03	00590	HOSPITAL BILLING				5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT-SCC				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC				8.01
9.00	00900	HOUSEKEEPING				9.00
9.01	00901	HOUSEKEEPING-SCC				9.01
10.00	01000	DIETARY				10.00
10.01	01001	DIETARY-SCC				10.01
11.00	01100	CAFETERIA				11.00
11.01	01101	CAFETERIA-SCC				11.01
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	778,906		30.00
42.00	04200	SUBPROVIDER	0	0		42.00
44.00	04400	SKILLED NURSING FACILITY	0	194		44.00
46.00	04600	OTHER LONG TERM CARE	0	10,888		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	653,602		50.00
53.00	05300	ANESTHESIOLOGY	0	26,857		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	488,193		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	107,344		60.00
64.00	06400	INTRAVENOUS THERAPY	0	3,413		64.00
65.00	06500	RESPIRATORY THERAPY	0	16,790		65.00
66.00	06600	PHYSICAL THERAPY	0	289,144		66.00
66.01	06601	CARDIAC REHAB	0	28,583		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	23,193		67.00
68.00	06800	SPEECH PATHOLOGY	0	2,445		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	42,246		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	62,251		73.00
76.00	03020	SLEEP LAB	0	0		76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0		76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	352,199		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	19,131		88.01
90.00	09000	CLINIC	0	75,820		90.00
91.00	09100	EMERGENCY	0	353,362		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	04040	FAMILY PRACTICE	0	0		93.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,334,561		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,062		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0		192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0		194.00
194.01	07951	ASSISTED LIVING UNITS	0	43,458		194.01
194.02	07952	ADULT DAY CARE	0	3,468		194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0		194.03

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
194.04	07954	IDLE SPACE	0	2,108		194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	21,830		194.05
200.00		Cross Foot Adjustments	0	10,635		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,431,122		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW ALU BLDG (SQUARE FEET)	NEW 2007 HOSPITAL (SQUARE FEET)	NEW 2007 MOB (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	
			1.00	1.01	1.02	1.03	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	50,914					1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG	0	29,602				1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL	0	0	52,376			1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB	0	0	0	0		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					69,389	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00570	ADMITTING	0	0	757	0	0	5.01
5.02	00550	INFORMATION TECHNOLOGY	578	0	376	0	0	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	8,429	8,900	4,543	0	5,864	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	3,523	0	0	7.00
7.01	00701	OPERATION OF PLANT-SCC	1,940	0	0	0	1,758	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	356	0	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	194	0	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	0	270	0	0	9.00
9.01	00901	HOUSEKEEPING-SCC	369	0	0	0	0	9.01
10.00	01000	DIETARY	0	0	3,206	0	0	10.00
10.01	01001	DIETARY-SCC	1,434	0	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	643	0	128	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	682	0	0	14.00
15.00	01500	PHARMACY	0	0	773	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	687	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	8,850	0	0	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	1,683	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	17,508	0	0	0	51,022	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	5,384	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	54	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,631	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	1,076	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	188	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	4,325	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	300	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	372	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	5,733	0	80	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	1,000	0	0	90.00
91.00	09100	EMERGENCY	0	0	5,541	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,778	8,900	51,755	0	58,724	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	297	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	19,152	0	0	6,654	194.01
194.02	07952	ADULT DAY CARE	0	1,550	0	0	4,011	194.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW ALU BLDG (SQUARE FEET)	NEW 2007 HOSPITAL (SQUARE FEET)	NEW 2007 MOB (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	
			1.00	1.01	1.02	1.03	2.00	
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	18,136	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	324	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,399	52,816	2,347,888	0	11,886	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.106042	1.784204	44.827555	0.000000	0.171295	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	CAPITAL RELATED COSTS NEW MVBLE EQUIP NEW HO (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	INFORMATION TECHNOLOGY (NO. OF COMPUTERS)	HOSPITAL BILLING (GROSS CHARGES HOSP BILLING)	
			2.01	4.00	5.01	5.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	894,695					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,636,732				4.00
5.01	00570	ADMITTING	0	489,615	39,789,133			5.01
5.02	00550	INFORMATION TECHNOLOGY	66,601	345,111	0	216		5.02
5.03	00590	HOSPITAL BILLING	0	0	0	0	42,857,849	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	102,402	837,150	0	32	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	30,838	155,289	0	6	0	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	98,666	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	447	0	0	0	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	0	0	0	8.01
9.00	00900	HOUSEKEEPING	260	238,607	0	0	0	9.00
9.01	00901	HOUSEKEEPING-SCC	0	92,634	0	0	0	9.01
10.00	01000	DIETARY	25,165	308,137	0	4	0	10.00
10.01	01001	DIETARY-SCC	0	333,861	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	395,838	0	1	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	116,226	0	0	0	14.00
15.00	01500	PHARMACY	1,556	0	0	3	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	108	252,565	0	4	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	525,962	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	47,822	1,129,322	3,882,439	20	3,882,439	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	1,878,388	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	289,942	519,824	6,389,235	19	6,389,235	50.00
53.00	05300	ANESTHESIOLOGY	17,814	0	1,410,917	0	1,410,917	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	227,134	472,300	7,883,494	12	7,883,494	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	18,788	422,853	4,762,694	5	4,762,694	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	942,417	0	942,417	64.00
65.00	06500	RESPIRATORY THERAPY	4,682	0	66,698	0	66,698	65.00
66.00	06600	PHYSICAL THERAPY	9,576	1,603,872	4,438,532	30	4,438,532	66.00
66.01	06601	CARDIAC REHAB	7,555	134,034	241,760	3	241,760	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	133,899	396,117	1	396,117	67.00
68.00	06800	SPEECH PATHOLOGY	0	90,839	250,138	0	250,138	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,188,525	0	2,188,525	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,550,175	0	3,550,175	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,485	598,072	0	32	2,192,669	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,345	221,808	0	11	672,548	88.01
90.00	09000	CLINIC	7,476	262,421	0	14	203,499	90.00
91.00	09100	EMERGENCY	19,101	542,386	3,385,992	12	3,385,992	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	886,097	12,199,679	39,789,133	209	42,857,849	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	90	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	6,996	424,743	0	0	0	194.01

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	CAPITAL RELATED COSTS NEW MVBLE EQUIP NEW HO (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	INFORMATION TECHNOLOGY (NO. OF COMPUTERS)	HOSPITAL BILLING (GROSS CHARGES HOSP BILLING)	
			2.01	4.00	5.01	5.02	5.03	
194.02	07952	ADULT DAY CARE	0	0	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	1,512	12,310	0	7	0	194.05
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)	1,011,964	3,597,764	672,124	1,015,536	393,455	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.131071	0.284707	0.016892	4,701.555556	0.009180	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		0	33,934	92,246	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000000	0.000853	427.064815	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FT)	OPERATION OF PLANT-SCC (SQUARE FT SCC)	
			5A.04	5.04	6.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	-2,640,729	23,785,999				5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0			6.00
7.00	00700	OPERATION OF PLANT	0	1,022,228	0	43,177		7.00
7.01	00701	OPERATION OF PLANT-SCC	-330,364	0	0	0	61,529	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	104,645	0	356	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	-32,834	0	0	0	194	8.01
9.00	00900	HOUSEKEEPING	0	365,113	0	270	0	9.00
9.01	00901	HOUSEKEEPING-SCC	-141,098	0	0	0	369	9.01
10.00	01000	DIETARY	0	696,849	0	3,206	0	10.00
10.01	01001	DIETARY-SCC	-683,881	0	0	0	1,434	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	529,914	0	128	643	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	195,953	0	682	0	14.00
15.00	01500	PHARMACY	0	50,517	0	773	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	392,977	0	687	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	720,838	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,327,337	0	8,850	0	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	-14,983	0	0	0	1,683	44.00
46.00	04600	OTHER LONG TERM CARE	-2,800,039	0	0	0	17,508	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,890,674	0	5,384	0	50.00
53.00	05300	ANESTHESIOLOGY	0	59,355	0	54	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,857,942	0	3,631	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,436,376	0	1,076	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	62,618	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	72,759	0	188	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,596,933	0	4,675	0	66.00
66.01	06601	CARDIAC REHAB	0	224,838	0	300	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	228,954	0	372	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	131,806	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,136,395	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	889,893	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,604,187	0	5,733	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	795,793	0	0	0	88.01
90.00	09000	CLINIC	0	769,678	0	650	0	90.00
91.00	09100	EMERGENCY	0	2,540,358	0	5,541	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,643,928	23,704,930	0	42,556	21,831	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,416	0	297	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	-612,023	0	0	0	19,152	194.01
194.02	07952	ADULT DAY CARE	-3,453	0	0	0	1,550	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	1,923	0	0	18,996	194.04

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FT)	OPERATION OF PLANT-SCC (SQUARE FT SCC)	
			5A.04	5.04	6.00	7.00	7.01	
194.05	07955	COMMUNITY FITNESS CENTER	0	65,730	0	324	0	194.05
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)		2,640,729	0	1,135,716	330,364	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.111020	0.000000	26.303727	5.369241	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		350,921	0	210,450	507	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.014753	0.000000	4.874123	0.008240	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: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	LAUNDRY & LINEN SERVICE-SCC (PATIENT DAYS SCC)	HOUSEKEEPING (SQUARE FT)	HOUSEKEEPING-SCC (SQUARE FT SCC)	DIETARY (PATIENT DAYS)	
			8.00	8.01	9.00	9.01	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	2,617					8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	15,685				8.01
9.00	00900	HOUSEKEEPING	0	0	38,840			9.00
9.01	00901	HOUSEKEEPING-SCC	0	0	0	41,970		9.01
10.00	01000	DIETARY	0	0	3,206	0	2,617	10.00
10.01	01001	DIETARY-SCC	0	0	0	1,434	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	0	128	643	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	682	0	0	14.00
15.00	01500	PHARMACY	0	0	773	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	687	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,617	0	8,850	0	2,617	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	1,683	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	15,685	0	17,508	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	5,384	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	54	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,631	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	1,076	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	188	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,704	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	175	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	135	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	5,908	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	600	0	0	90.00
91.00	09100	EMERGENCY	0	0	5,541	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,617	15,685	38,722	21,268	2,617	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	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	0	19,152	0	194.01
194.02	07952	ADULT DAY CARE	0	0	0	1,550	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	LAUNDRY & LINEN SERVICE-SCC (PATIENT DAYS SCC)	HOUSEKEEPING (SQUARE FT)	HOUSEKEEPING-SCC (SQUARE FT SCC)	DIETARY (PATIENT DAYS)	
			8.00	8.01	9.00	9.01	10.00	
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	118	0	0	194.05
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)	125,627	33,876	412,750	143,079	892,613	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	48.004203	2.159770	10.626931	3.409078	341.082537	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	19,744	23	19,100	42	201,372	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.544517	0.001466	0.491761	0.001001	76.947650	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: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	DIETARY-SCC (PATIENT DAYS SCC)	CAFETERIA (FTE)	CAFETERIA-SCC (FTE'S -SCC)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	
			10.01	11.00	11.01	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING-SCC						9.01
10.00	01000	DIETARY						10.00
10.01	01001	DIETARY-SCC	24,474					10.01
11.00	01100	CAFETERIA	0	0				11.00
11.01	01101	CAFETERIA-SCC	0	0	0			11.01
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,959		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	1,867,451	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	7,695	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	1,650	62,954	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	15,685	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	645	223,562	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	26,438	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	41,917	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	38,048	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	43,370	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	76,572	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	5,224	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	2,015	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,079,334	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	378	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	81,695	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	25,621	88.01
90.00	09000	CLINIC	0	0	0	0	77,353	90.00
91.00	09100	EMERGENCY	0	0	0	664	75,275	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,685	0	0	2,959	1,867,451	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	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	8,789	0	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	0	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	DIETARY-SCC (PATIENT DAYS SCC)	CAFETERIA (FTE)	CAFETERIA-SCC (FTE'S -SCC)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	
			10.01	11.00	11.01	13.00	14.00	
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.05
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)	696,469	0	0	599,116	242,895	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.457506	0.000000	0.000000	202.472457	0.130068	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	165	0	0	14,744	37,122	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006742	0.000000	0.000000	4.982764	0.019878	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: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	PHARMACY (GROSS CHARGES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES HOSP BILLING)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)		
			15.00	16.00	19.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG					1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL					1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB					1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00550	INFORMATION TECHNOLOGY					5.02
5.03	00590	HOSPITAL BILLING					5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT-SCC					7.01
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC					8.01
9.00	00900	HOUSEKEEPING					9.00
9.01	00901	HOUSEKEEPING-SCC					9.01
10.00	01000	DIETARY					10.00
10.01	01001	DIETARY-SCC					10.01
11.00	01100	CAFETERIA					11.00
11.01	01101	CAFETERIA-SCC					11.01
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
15.00	01500	PHARMACY	3,550,175				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	42,857,849			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	3,882,439	0		30.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	6,389,235	0		50.00
53.00	05300	ANESTHESIOLOGY	0	1,410,917	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,883,494	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	4,762,694	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	942,417	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	66,698	0		65.00
66.00	06600	PHYSICAL THERAPY	0	4,438,532	0		66.00
66.01	06601	CARDIAC REHAB	0	241,760	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	396,117	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	250,138	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,188,525	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,550,175	3,550,175	0		73.00
76.00	03020	SLEEP LAB	0	0	0		76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0		76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	2,192,669	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	672,548	0		88.01
90.00	09000	CLINIC	0	203,499	0		90.00
91.00	09100	EMERGENCY	0	3,385,992	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	FAMILY PRACTICE	0	0	0		93.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,550,175	42,857,849	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0		192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0		194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	0		194.01
194.02	07952	ADULT DAY CARE	0	0	0		194.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/23/2024 11:09 am

		Cost Center Description	PHARMACY (GROSS CHARGES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES HOSP BILLING)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)		
			15.00	16.00	19.00		
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0		194.03
194.04	07954	IDLE SPACE	0	0	0		194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0		194.05
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)	84,673	462,978	800,865		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.023850	0.010803	8,008.650000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	42,586	42,265	10,635		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.011995	0.000986	106.350000		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: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/23/2024 11:09 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	4,315,003		4,315,003	0	4,315,003	30.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	29,756		29,756	0	29,756	44.00
46.00	04600	OTHER LONG TERM CARE	3,433,962		3,433,962	0	3,433,962	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,528,107		2,528,107	0	2,528,107	50.00
53.00	05300	ANESTHESIOLOGY	887,485		887,485	0	887,485	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,288,908		2,288,908	0	2,288,908	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	1,687,031		1,687,031	0	1,687,031	60.00
64.00	06400	INTRAVENOUS THERAPY	84,700		84,700	0	84,700	64.00
65.00	06500	RESPIRATORY THERAPY	94,142	0	94,142	0	94,142	65.00
66.00	06600	PHYSICAL THERAPY	3,084,232	0	3,084,232	0	3,084,232	66.00
66.01	06601	CARDIAC REHAB	262,163	0	262,163	0	262,163	66.01
67.00	06700	OCCUPATIONAL THERAPY	270,550	0	270,550	0	270,550	67.00
68.00	06800	SPEECH PATHOLOGY	149,403	0	149,403	0	149,403	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,426,588		1,426,588	0	1,426,588	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,111,764		1,111,764	0	1,111,764	73.00
76.00	03020	SLEEP LAB	0		0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0		0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0		0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,141,206		3,141,206	0	3,141,206	88.00
88.01	08801	RURAL HEALTH CLINIC II	894,740		894,740	0	894,740	88.01
90.00	09000	CLINIC	890,860		890,860	0	890,860	90.00
91.00	09100	EMERGENCY	3,207,834		3,207,834	0	3,207,834	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	421,126		421,126		421,126	92.00
93.00	04040	FAMILY PRACTICE	0		0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	30,209,560	0	30,209,560	0	30,209,560	200.00
201.00		Less Observation Beds	421,126		421,126		421,126	201.00
202.00		Total (see instructions)	29,788,434	0	29,788,434	0	29,788,434	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/23/2024 11:09 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,431,683		3,431,683			30.00
42.00	04200	SUBPROVIDER	0		0			42.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
46.00	04600	OTHER LONG TERM CARE	4,237,764		4,237,764			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	800,739	5,588,496	6,389,235	0.395682	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	24,373	1,386,545	1,410,918	0.629012	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	223,308	7,660,186	7,883,494	0.290342	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	273,537	4,489,157	4,762,694	0.354218	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	8,517	933,900	942,417	0.089875	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	23,786	42,913	66,699	1.411445	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	737,880	3,700,651	4,438,531	0.694877	0.000000	66.00
66.01	06601	CARDIAC REHAB	0	241,760	241,760	1.084394	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	232,257	163,860	396,117	0.683005	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	114,767	135,371	250,138	0.597282	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	370,207	1,818,318	2,188,525	0.651849	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	871,266	2,678,909	3,550,175	0.313158	0.000000	73.00
76.00	03020	SLEEP LAB	0	0	0	0.000000	0.000000	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0.000000	0.000000	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,192,669	2,192,669			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	672,548	672,548			88.01
90.00	09000	CLINIC	0	203,499	203,499	4.377712	0.000000	90.00
91.00	09100	EMERGENCY	10,000	3,375,991	3,385,991	0.947384	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,192	448,564	450,756	0.934266	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0.000000	0.000000	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,362,276	35,733,337	47,095,613			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,362,276	35,733,337	47,095,613			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/23/2024 11:09 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
42.00	04200	SUBPROVIDER			42.00
44.00	04400	SKILLED NURSING FACILITY			44.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.395682		50.00
53.00	05300	ANESTHESIOLOGY	0.629012		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.290342		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.354218		60.00
64.00	06400	INTRAVENOUS THERAPY	0.089875		64.00
65.00	06500	RESPIRATORY THERAPY	1.411445		65.00
66.00	06600	PHYSICAL THERAPY	0.694877		66.00
66.01	06601	CARDIAC REHAB	1.084394		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.683005		67.00
68.00	06800	SPEECH PATHOLOGY	0.597282		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.651849		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313158		73.00
76.00	03020	SLEEP LAB	0.000000		76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000		76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
90.00	09000	CLINIC	4.377712		90.00
91.00	09100	EMERGENCY	0.947384		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.934266		92.00
93.00	04040	FAMILY PRACTICE	0.000000		93.00
		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: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/23/2024 11:09 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	4,315,003		4,315,003	0	4,315,003	30.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	29,756		29,756	0	29,756	44.00
46.00	04600	OTHER LONG TERM CARE	3,433,962		3,433,962	0	3,433,962	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,528,107		2,528,107	0	2,528,107	50.00
53.00	05300	ANESTHESIOLOGY	887,485		887,485	0	887,485	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,288,908		2,288,908	0	2,288,908	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	1,687,031		1,687,031	0	1,687,031	60.00
64.00	06400	INTRAVENOUS THERAPY	84,700		84,700	0	84,700	64.00
65.00	06500	RESPIRATORY THERAPY	94,142	0	94,142	0	94,142	65.00
66.00	06600	PHYSICAL THERAPY	3,084,232	0	3,084,232	0	3,084,232	66.00
66.01	06601	CARDIAC REHAB	262,163	0	262,163	0	262,163	66.01
67.00	06700	OCCUPATIONAL THERAPY	270,550	0	270,550	0	270,550	67.00
68.00	06800	SPEECH PATHOLOGY	149,403	0	149,403	0	149,403	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,426,588		1,426,588	0	1,426,588	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,111,764		1,111,764	0	1,111,764	73.00
76.00	03020	SLEEP LAB	0		0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0		0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0		0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,141,206		3,141,206	0	3,141,206	88.00
88.01	08801	RURAL HEALTH CLINIC II	894,740		894,740	0	894,740	88.01
90.00	09000	CLINIC	890,860		890,860	0	890,860	90.00
91.00	09100	EMERGENCY	3,207,834		3,207,834	0	3,207,834	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	421,126		421,126		421,126	92.00
93.00	04040	FAMILY PRACTICE	0		0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	30,209,560	0	30,209,560	0	30,209,560	200.00
201.00		Less Observation Beds	421,126		421,126		421,126	201.00
202.00		Total (see instructions)	29,788,434	0	29,788,434	0	29,788,434	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/23/2024 11:09 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,431,683		3,431,683			30.00
42.00	04200	SUBPROVIDER	0		0			42.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
46.00	04600	OTHER LONG TERM CARE	4,237,764		4,237,764			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	800,739	5,588,496	6,389,235	0.395682	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	24,373	1,386,545	1,410,918	0.629012	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	223,308	7,660,186	7,883,494	0.290342	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	273,537	4,489,157	4,762,694	0.354218	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	8,517	933,900	942,417	0.089875	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	23,786	42,913	66,699	1.411445	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	737,880	3,700,651	4,438,531	0.694877	0.000000	66.00
66.01	06601	CARDIAC REHAB	0	241,760	241,760	1.084394	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	232,257	163,860	396,117	0.683005	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	114,767	135,371	250,138	0.597282	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	370,207	1,818,318	2,188,525	0.651849	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	871,266	2,678,909	3,550,175	0.313158	0.000000	73.00
76.00	03020	SLEEP LAB	0	0	0	0.000000	0.000000	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0.000000	0.000000	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,192,669	2,192,669	1.432595	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	672,548	672,548	1.330373	0.000000	88.01
90.00	09000	CLINIC	0	203,499	203,499	4.377712	0.000000	90.00
91.00	09100	EMERGENCY	10,000	3,375,991	3,385,991	0.947384	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,192	448,564	450,756	0.934266	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0.000000	0.000000	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,362,276	35,733,337	47,095,613			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,362,276	35,733,337	47,095,613			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/23/2024 11:09 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
42.00	04200	SUBPROVIDER			42.00
44.00	04400	SKILLED NURSING FACILITY			44.00
46.00	04600	OTHER LONG TERM CARE			46.00
		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
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
66.01	06601	CARDIAC REHAB	0.000000		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	SLEEP LAB	0.000000		76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000		76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040	FAMILY PRACTICE	0.000000		93.00
		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: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/23/2024 11:09 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	653,602	6,389,235	0.102297	503,682	51,525	50.00
53.00	05300	ANESTHESIOLOGY	26,857	1,410,918	0.019035	16,047	305	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	488,193	7,883,494	0.061926	90,661	5,614	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	107,344	4,762,694	0.022539	117,493	2,648	60.00
64.00	06400	INTRAVENOUS THERAPY	3,413	942,417	0.003622	107	0	64.00
65.00	06500	RESPIRATORY THERAPY	16,790	66,699	0.251728	10,151	2,555	65.00
66.00	06600	PHYSICAL THERAPY	289,144	4,438,531	0.065144	109,938	7,162	66.00
66.01	06601	CARDIAC REHAB	28,583	241,760	0.118229	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	23,193	396,117	0.058551	28,289	1,656	67.00
68.00	06800	SPEECH PATHOLOGY	2,445	250,138	0.009775	15,036	147	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,246	2,188,525	0.019303	233,529	4,508	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,251	3,550,175	0.017535	303,497	5,322	73.00
76.00	03020	SLEEP LAB	0	0	0.000000	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0.000000	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	352,199	2,192,669	0.160626	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	19,131	672,548	0.028446	0	0	88.01
90.00	09000	CLINIC	75,820	203,499	0.372582	0	0	90.00
91.00	09100	EMERGENCY	353,362	3,385,991	0.104360	3,388	354	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	76,018	450,756	0.168646	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0.000000	0	0	93.00
200.00		Total (lines 50 through 199)	2,620,591	39,426,166		1,431,818	81,796	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/23/2024 11:09 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	800,865	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	800,865	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/23/2024 11:09 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	6,389,235	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	800,865	0	1,410,918	0.567620	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,883,494	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	4,762,694	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	942,417	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	66,699	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,438,531	0.000000	66.00
66.01	06601	CARDIAC REHAB	0	0	0	241,760	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	396,117	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	250,138	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,188,525	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,550,175	0.000000	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0.000000	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0.000000	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,192,669	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	672,548	0.000000	88.01
90.00	09000	CLINIC	0	0	0	203,499	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	3,385,991	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	450,756	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0.000000	93.00
200.00		Total (lines 50 through 199)	0	800,865	0	39,426,166		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/23/2024 11:09 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	503,682	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	16,047	9,109	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	90,661	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	117,493	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	107	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	10,151	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	109,938	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	28,289	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	15,036	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	233,529	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	303,497	0	0	0	73.00
76.00	03020	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	3,388	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		1,431,818	9,109	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/23/2024 11:09 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	0.395682	0	1,576,728	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.629012	0	325,867	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.290342	0	2,519,672	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.354218	0	1,356,919	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.089875	0	314,872	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1.411445	0	16,139	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.694877	0	1,625,864	0	0	66.00
66.01	06601	CARDIAC REHAB	1.084394	0	156,355	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.683005	0	41,244	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.597282	0	57,985	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.651849	0	393,357	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313158	0	800,955	1,116	0	73.00
76.00	03020	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	4.377712	0	46,545	0	0	90.00
91.00	09100	EMERGENCY	0.947384	0	1,047,492	4,712	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.934266	0	291,090	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	10,571,084	5,828	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	10,571,084	5,828	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/23/2024 11:09 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	623,883	0		50.00
53.00	05300	ANESTHESIOLOGY	204,974	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	731,567	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	480,645	0		60.00
64.00	06400	INTRAVENOUS THERAPY	28,299	0		64.00
65.00	06500	RESPIRATORY THERAPY	22,779	0		65.00
66.00	06600	PHYSICAL THERAPY	1,129,775	0		66.00
66.01	06601	CARDIAC REHAB	169,550	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	28,170	0		67.00
68.00	06800	SPEECH PATHOLOGY	34,633	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	256,409	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	250,825	349		73.00
76.00	03020	SLEEP LAB	0	0		76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0		76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
90.00	09000	CLINIC	203,761	0		90.00
91.00	09100	EMERGENCY	992,377	4,464		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	271,955	0		92.00
93.00	04040	FAMILY PRACTICE	0	0		93.00
200.00		Subtotal (see instructions)	5,429,602	4,813		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,429,602	4,813		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1302 | Component CCN: 14-Z302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V | Date/Time Prepared: 2/23/2024 11:09 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.395682	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.629012	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.290342	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.354218	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.089875	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1.411445	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.694877	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	1.084394	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.683005	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.597282	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.651849	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313158	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	4.377712	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.947384	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.934266	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1302 | Component CCN: 14-Z302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V | Date/Time Prepared: 2/23/2024 11:09 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
66.01	06601	CARDIAC REHAB	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	SLEEP LAB	0	0		76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0		76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	FAMILY PRACTICE	0	0		93.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1302 | Component CCN: 14-6140 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/23/2024 11:09 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	800,865	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	800,865	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1302 | Component CCN: 14-6140 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/23/2024 11:09 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	6,389,235	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	800,865	0	1,410,918	0.567620	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,883,494	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	4,762,694	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	942,417	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	66,699	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,438,531	0.000000	66.00
66.01	06601	CARDIAC REHAB	0	0	0	241,760	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	396,117	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	250,138	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,188,525	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,550,175	0.000000	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0.000000	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0.000000	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,192,669	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	672,548	0.000000	88.01
90.00	09000	CLINIC	0	0	0	203,499	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	3,385,991	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	450,756	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0.000000	93.00
200.00		Total (lines 50 through 199)	0	800,865	0	39,426,166		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1302 | Component CCN: 14-6140 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/23/2024 11:09 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/23/2024 11:09 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)	2,617	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,029	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)	786	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	278	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)	1,167	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	53	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)	90	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	500	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)	275	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)	908	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	188.64	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	194.30	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,315,003	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)	9,998	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)	17,487	25.00
26.00	Total swing-bed cost (see instructions)	2,531,713	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,783,290	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,783,290	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,733.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	866,515	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)	866,515	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/23/2024 11:09 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)	646,846	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)	1,513,361	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)	476,583	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,573,591	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	2,050,174	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)	243	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,733.03	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1302	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/23/2024 11:09 am
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	421,126	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	778,906	4,315,003	0.180511	421,126	76,018	90.00
91.00	Nursing Program cost	0	4,315,003	0.000000	421,126	0	91.00
92.00	Allied health cost	0	4,315,003	0.000000	421,126	0	92.00
93.00	All other Medical Education	0	4,315,003	0.000000	421,126	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/23/2024 11:09 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	0	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)	0	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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	0	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)	0	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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	29,756	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)	0	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)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	29,756	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)	29,756	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1302 | Component CCN: 14-6140 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/23/2024 11:09 am

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)		48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)		48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
55.01	Permanent adjustment amount per discharge		55.01
55.02	Adjustment amount per discharge (contractor use only)		55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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)		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)		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	29,756	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	0.00	71.00
72.00	Program routine service cost (line 9 x line 71)	0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	0	83.00
84.00	Program inpatient ancillary services (see instructions)	0	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	0	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/23/2024 11:09 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description		
		1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	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	0	0	0.000000	0	0	90.00
91.00	Nursing Program cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/23/2024 11:09 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		1,168,542		30.00
42.00	04200	SUBPROVIDER		0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.395682	503,682	199,298	50.00
53.00	05300	ANESTHESIOLOGY	0.629012	16,047	10,094	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.290342	90,661	26,323	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.354218	117,493	41,618	60.00
64.00	06400	INTRAVENOUS THERAPY	0.089875	107	10	64.00
65.00	06500	RESPIRATORY THERAPY	1.411445	10,151	14,328	65.00
66.00	06600	PHYSICAL THERAPY	0.694877	109,938	76,393	66.00
66.01	06601	CARDIAC REHAB	1.084394	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.683005	28,289	19,322	67.00
68.00	06800	SPEECH PATHOLOGY	0.597282	15,036	8,981	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.651849	233,529	152,226	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313158	303,497	95,043	73.00
76.00	03020	SLEEP LAB	0.000000	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	4.377712	0	0	90.00
91.00	09100	EMERGENCY	0.947384	3,388	3,210	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.934266	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,431,818	646,846	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,431,818		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3

Component CCN: 14-Z302 | Date/Time Prepared: 2/23/2024 11:09 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
42.00	04200	SUBPROVIDER				42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.395682	7,601	3,008	50.00
53.00	05300	ANESTHESIOLOGY	0.629012	362	228	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.290342	38,690	11,233	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.354218	85,800	30,392	60.00
64.00	06400	INTRAVENOUS THERAPY	0.089875	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1.411445	4,670	6,591	65.00
66.00	06600	PHYSICAL THERAPY	0.694877	473,132	328,769	66.00
66.01	06601	CARDIAC REHAB	1.084394	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.683005	160,418	109,566	67.00
68.00	06800	SPEECH PATHOLOGY	0.597282	85,021	50,782	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.651849	1,032	673	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313158	373,042	116,821	73.00
76.00	03020	SLEEP LAB	0.000000	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	4.377712	0	0	90.00
91.00	09100	EMERGENCY	0.947384	2,410	2,283	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.934266	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,232,178	660,346	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,232,178		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3

Component CCN: 14-6140 | Date/Time Prepared: 2/23/2024 11:09 am

Title XVIII | Skilled Nursing Facility | PPS

		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
42.00	04200	SUBPROVIDER				42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.395682	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.629012	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.290342	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.354218	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.089875	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1.411445	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.694877	0	0	66.00
66.01	06601	CARDIAC REHAB	1.084394	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.683005	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.597282	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.651849	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313158	0	0	73.00
76.00	03020	SLEEP LAB	0.000000	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	4.377712	0	0	90.00
91.00	09100	EMERGENCY	0.947384	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.934266	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1302	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/23/2024 11:09 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,434,415	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,434,415	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	5,488,759	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)	37,783	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,793,629	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,657,347	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	3,657,347	30.00
31.00	Primary payer payments	2,969	31.00
32.00	Subtotal (line 30 minus line 31)	3,654,378	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	3,654,378	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,654,378	40.00
40.01	Sequestration adjustment (see instructions)	73,088	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,696,286	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)	-114,996	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1302	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/23/2024 11:09 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/23/2024 11:09 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments		3.00
4.00	Outlier payment (see instructions)		4.00
4.01	Outlier reconciliation amount (see instructions)		4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	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)	0	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)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		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)	0	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	0	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	0	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		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)	0	40.00
40.01	Sequestration adjustment (see instructions)	0	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	0	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)	0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/23/2024 11:09 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
94.00	Total (sum of lines 91 and 93)		94.00
		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days		200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/23/2024 11:09 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,302,719		3,758,237	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	05/08/2023	45,840		0	3.01
3.02		09/19/2023	7,626		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	05/08/2023	46,853	3.50
3.51			0	09/19/2023	15,098	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		53,466		-61,951	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)		1,356,185		3,696,286	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		35,503		114,996	6.02
7.00	Total Medicare program liability (see instructions)		1,320,682		3,581,290	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: 14-1302 | Component CCN: 14-Z302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/23/2024 11:09 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,407,522		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	05/08/2023	73,467		0	3.01
3.02		09/19/2023	27,545		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)		101,012		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,508,534		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		130,524		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,639,058		0	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: 14-1302	Period: From 10/01/2022 To 09/30/2023	Worksheet E-1 Part I Date/Time Prepared: 2/23/2024 11:09 am
Component CCN: 14-6140		
Title XVIII	Skilled Nursing Facility	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		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		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	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)		0		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)		0		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		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: 14-1302	Period: From 10/01/2022 To 09/30/2023	Worksheet E-1 Part II Date/Time Prepared: 2/23/2024 11:09 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: 14-1302 | Component CCN: 14-Z302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-2 | Date/Time Prepared: 2/23/2024 11:09 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)	2,070,676	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)	666,949	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	1,183	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,737,625	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,737,625	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	2,737,625	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	44,709	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	2,692,916	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,692,916	0	19.00
19.01	Sequestration adjustment (see instructions)	53,858	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	2,508,534	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	130,524	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: 14-1302	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part V Date/Time Prepared: 2/23/2024 11:09 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,513,361	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)	1,513,361	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,528,495	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)	1,528,495	19.00
20.00	Deductibles (exclude professional component)	180,860	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,347,635	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,347,635	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	0	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,347,635	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)	1,347,635	30.00
30.01	Sequestration adjustment (see instructions)	26,953	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,356,185	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)	-35,503	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part VI Date/Time Prepared: 2/23/2024 11:09 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	0	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	0	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	0	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	0	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.98	Recovery of accelerated depreciation.	0	14.98
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	0	15.00
15.01	Sequestration adjustment (see instructions)	0	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)	0	15.75
16.00	Interim payments	0	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

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

Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G | Date/Time Prepared: 2/23/2024 11:09 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	2,660,323	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,857,147	0	0	0	4.00
5.00	Other receivable	109,184	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,753,107	0	0	0	6.00
7.00	Inventory	495,563	0	0	0	7.00
8.00	Prepaid expenses	345,903	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,715,013	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	448,597	0	0	0	12.00
13.00	Land improvements	4,011,958	0	0	0	13.00
14.00	Accumulated depreciation	-3,096,623	0	0	0	14.00
15.00	Buildings	38,956,780	0	0	0	15.00
16.00	Accumulated depreciation	-25,183,324	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	9,746,688	0	0	0	23.00
24.00	Accumulated depreciation	-6,685,117	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	2,772,852	0	0	0	27.00
28.00	Accumulated depreciation	-2,691,290	0	0	0	28.00
29.00	Minor equipment-nondepreciable	5,232,226	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	23,512,747	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	16,035,197	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,674,543	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	17,709,740	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	49,937,500	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	971,797	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,539,358	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,053,734	0	0	0	40.00
41.00	Deferred income	106,568	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	250,000	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,921,457	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	5,050,000	0	0	0	46.00
47.00	Notes payable	32,616,250	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	667,872	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	38,334,122	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	42,255,579	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	7,681,921				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	7,681,921	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	49,937,500	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-1 | Date/Time Prepared: 2/23/2024 11:09 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		6,089,052		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,536,160				2.00
3.00	Total (sum of line 1 and line 2)		7,625,212		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	CHANGE IN NET ASSETS	56,709		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)		56,709		0		10.00
11.00	Subtotal (line 3 plus line 10)		7,681,921		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		7,681,921		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00	CHANGE IN NET ASSETS		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: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/23/2024 11:09 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,161,203		2,161,203	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	1,270,480		1,270,480	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	4,237,764		4,237,764	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,669,447		7,669,447	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)	7,669,447		7,669,447	17.00
18.00	Ancillary services	3,680,637	28,840,066	32,520,703	18.00
19.00	Outpatient services	2,192	4,038,054	4,040,246	19.00
20.00	RURAL HEALTH CLINIC	0	2,192,669	2,192,669	20.00
20.01	RURAL HEALTH CLINIC II	0	672,548	672,548	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	429,891	6,136,698	6,566,589	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,782,167	41,880,035	53,662,202	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		35,805,274		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	PROVISION FOR BAD DEBTS	498,141			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)		498,141		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		36,303,415		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1302 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-3 | Date/Time Prepared: 2/23/2024 11:09 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	53,662,202	1.00
2.00	Less contractual allowances and discounts on patients' accounts	19,400,660	2.00
3.00	Net patient revenues (line 1 minus line 2)	34,261,542	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	36,303,415	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,041,873	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	130,334	6.00
7.00	Income from investments	467,983	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	212,459	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	1,099	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	18,440	22.00
23.00	Governmental appropriations	0	23.00
24.00	340B REVENUE	1,531,191	24.00
24.01	ASSISTED LIVING UNITS	806,534	24.01
24.02	MISCELLANEOUS REVENUE	77,110	24.02
24.03	FITNESS CENTER REVENUE	176,243	24.03
24.04	GRANT REVENUE	162,166	24.04
24.05	OTHER (SPECIFY)	0	24.05
24.06	OTHER (SPECIFY)	0	24.06
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	3,583,559	25.00
26.00	Total (line 5 plus line 25)	1,541,686	26.00
27.00	LOSS ON SALE OF EQUIPMENT	5,526	27.00
27.01	OTHER EXPENSES (SPECIFY)	0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	5,526	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,536,160	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302 | Component CCN: 14-8511 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/23/2024 11:09 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,137,161	0	1,137,161	-46,530	1,090,631	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	140,930	0	140,930	7,328	148,258	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	343,925	0	343,925	0	343,925	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	44,347	44,347	-12,277	32,070	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,622,016	44,347	1,666,363	-51,479	1,614,884	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	119,015	119,015	0	119,015	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	119,015	119,015	0	119,015	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,622,016	163,362	1,785,378	-51,479	1,733,899	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	0	0	0	0	29.00
30.00	Administrative Costs	235,728	70,486	306,214	0	306,214	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	235,728	70,486	306,214	0	306,214	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,857,744	233,848	2,091,592	-51,479	2,040,113	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302 | Component CCN: 14-8511 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/23/2024 11:09 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	-42,256	1,048,375		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	148,258		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	343,925		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	32,070		9.00
10.00	Subtotal (sum of lines 1 through 9)	-42,256	1,572,628		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	119,015		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	119,015		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-42,256	1,691,643		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	0		29.00
30.00	Administrative Costs	0	306,214		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	306,214		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-42,256	1,997,857		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302 | Component CCN: 14-8557 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/23/2024 11:09 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	308,571	0	308,571	34,835	343,406	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	33,016	0	33,016	0	33,016	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	161,460	0	161,460	0	161,460	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	21,263	21,263	0	21,263	9.00
10.00	Subtotal (sum of lines 1 through 9)	503,047	21,263	524,310	34,835	559,145	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	21,049	21,049	0	21,049	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	21,049	21,049	0	21,049	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	503,047	42,312	545,359	34,835	580,194	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	7,923	7,923	0	7,923	29.00
30.00	Administrative Costs	55,147	21,554	76,701	10,913	87,614	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	55,147	29,477	84,624	10,913	95,537	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	558,194	71,789	629,983	45,748	675,731	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302 | Component CCN: 14-8557 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/23/2024 11:09 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	343,406		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	33,016		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	161,460		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	21,263		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	559,145		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	21,049		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	21,049		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	580,194		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	7,923		29.00
30.00	Administrative Costs	-2,500	85,114		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-2,500	93,037		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-2,500	673,231		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1302 | Component CCN: 14-8511 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/23/2024 11:09 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.69	7,828	2,910	7,828		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.96	2,130	2,100	2,016		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.65	9,958		9,844	9,958	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.65	9,958			9,958	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)					1,691,643	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)					1,691,643	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)					306,214	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,143,349	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,449,563	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,449,563	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,449,563	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,141,206	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1302 Component CCN: 14-8557

Period: From 10/01/2022 To 09/30/2023

Worksheet M-2 Date/Time Prepared: 2/23/2024 11:09 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	0.43	2,829	4,200	1,806		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.27	514	2,100	567		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.70	3,343		2,373	3,343	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.70	3,343			3,343	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)					580,194	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)					580,194	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)					93,037	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					221,509	15.00
16.00	Total overhead (sum of lines 14 and 15)					314,546	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					314,546	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					314,546	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					894,740	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1302 Component CCN: 14-8511	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/23/2024 11:09 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)			3,141,206	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			76,017	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			3,065,189	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			9,958	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)			9,958	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			307.81	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	356.56	370.10		8.00
9.00	Rate for Program covered visits (see instructions)	307.81	307.81		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	573	1,949		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	176,375	599,922		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	776,297		16.00
16.01	Total program charges (see instructions)(from contractor's records)		558,175		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		36,918		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		51,345		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.)		542,070		16.04
16.05	Total program cost (see instructions)	0	593,415		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		47,364		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		94,495		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		593,415		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		20,632		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		614,047		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	SEQUESTRATION		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)		614,047		26.00
26.01	Sequestration adjustment (see instructions)		12,281		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		459,322		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)		142,444		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: 14-1302 Component CCN: 14-8557	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/23/2024 11:09 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)			894,740	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			14,007	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			880,733	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,343	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)			3,343	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			263.46	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	270.71	281.00		8.00
9.00	Rate for Program covered visits (see instructions)	263.46	263.46		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	133	466		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	35,040	122,772		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	157,812		16.00
16.01	Total program charges (see instructions)(from contractor's records)		117,581		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,257		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		5,714		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.)		112,478		16.04
16.05	Total program cost (see instructions)	0	118,192		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		11,500		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		20,055		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		118,192		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,398		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		120,590		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)		120,590		26.00
26.01	Sequestration adjustment (see instructions)		2,412		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		112,486		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)		5,692		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: 14-1302 | Component CCN: 14-8511 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/23/2024 11:09 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,572,628	1,572,628	1,572,628	1,572,628	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000684	0.001916	0.000596	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,076	3,013	937	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	19,319	16,593	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	20,395	19,606	937	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,691,643	1,691,643	1,691,643	1,691,643	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,449,563	1,449,563	1,449,563	1,449,563	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.012056	0.011590	0.000554	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	17,476	16,800	803	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	37,871	36,406	1,740	0	10.00
11.00	Total number of injections/infusions (from your records)	156	437	136	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	242.76	83.31	12.79	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	36	136	44	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	8,739	11,330	563	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)		76,017	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)		20,632	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1302 | Component CCN: 14-8557 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/23/2024 11:09 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)	559,145	559,145	559,145	559,145	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000547	0.000957	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	306	535	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	5,486	2,756	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	5,792	3,291	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	580,194	580,194	580,194	580,194	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	314,546	314,546	314,546	314,546	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.009983	0.005672	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,140	1,784	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	8,932	5,075	0	0	10.00
11.00	Total number of injections/infusions (from your records)	40	70	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	223.30	72.50	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	1	30	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)	223	2,175	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)		14,007	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)		2,398	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1302 Component CCN: 14-8511	Period: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/23/2024 11:09 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		524,853	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		05/08/2023	65,531	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)		-65,531	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		459,322	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		142,444	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		601,766	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: 14-1302 | Component CCN: 14-8557 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-5 | Date/Time Prepared: 2/23/2024 11:09 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		116,969
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
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)		
	Program to Provider		
3.01			0
3.02			0
3.03			0
3.04			0
3.05			0
	Provider to Program		
3.50		05/08/2022	4,483
3.51			0
3.52			0
3.53			0
3.54			0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-4,483
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		112,486
	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)		
	Program to Provider		
5.01			0
5.02			0
5.03			0
	Provider to Program		
5.50			0
5.51			0
5.52			0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)		
6.01	SETTLEMENT TO PROVIDER		5,692
6.02	SETTLEMENT TO PROGRAM		0
7.00	Total Medicare program liability (see instructions)		118,178

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