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: 14-1311	Period: From 07/01/2022 To 06/30/2023	Worksheet S Parts I-III Date/Time Prepared: 11/29/2023 10:22 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/29/2023 Time: 10:22 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 FAIRFIELD MEMORIAL HOSPITAL (14-1311) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 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	Kristin Boldt		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	Kristin Boldt			2
3	Signatory Title	INTERIM CFO			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	411,909	-415,414	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	1	106		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		65,728		0	10.00
200.00	TOTAL	0	411,910	-349,579	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: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2023 10:22 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 303 NW 11TH ST	PO Box:			1.00
2.00	City: FAIRFIELD	State: IL	Zip Code: 62837	County:	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	FAIRFIELD MEMORIAL HOSPITAL	141311	99914	1	04/01/2001	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									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	FAIRFIELD MEMORIAL HOSPITAL	145552	99914		03/26/1985	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	FAIRFIELD MEMORIAL HOSPITAL HHA	147612	99914		05/01/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FAIRFIELD RHC	148500	99914		03/13/2009	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2022	06/30/2023	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: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2023 10:22 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: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2023 10:22 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: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/29/2023 10:22 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: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/29/2023 10:22 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)?	N	68.00

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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2023 10:22 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	221,848	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		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: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2023 10:22 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	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
					1.00	
	Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/29/2023 10:22 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.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/06/2023	Y	11/06/2023	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: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/29/2023 10:22 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.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LEXI	ROMMELMAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923500	LROMMELMAN@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1311	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part II Date/Time Prepared: 11/29/2023 10:22 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 11/29/2023 10:22 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	21	7,665	42,792.00	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)		21	7,665	42,792.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	2,520.00	0	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	45,312.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	30	10,950		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		55				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: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/29/2023 10:22 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,113	11	1,783			1.00
2.00	HMO and other (see instructions)	0	135				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	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,113	11	1,783			7.00
8.00	INTENSIVE CARE UNIT	42	0	105			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)	1,155	11	1,888	0.00	299.09	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	1,108	0	7,570	0.00	29.70	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	1,838	0	2,771	0.00	6.44	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	6,430	433	24,286	0.00	49.49	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	384.72	27.00
28.00	Observation Bed Days		7	793			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: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/29/2023 10:22 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	387	4	573	1.00
2.00	HMO and other (see instructions)			0	43		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	387	4	573	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-1311 | Component CCN: 14-7612 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-4 | Date/Time Prepared: 11/29/2023 10:22 am

Home Health Agency I | PPS

						1.00	
0.00	County				WAYNE		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	119.00	0.00	79.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			2.05	0.00	2.05	5.00
6.00	Direct Nursing Service			3.86	0.00	3.86	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.51	0.00	0.51	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.15	0.00	0.15	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.02	0.00	0.02	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
						CBSA Data	
						1.00	
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					1	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).					99914	20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	875	114	16	12	1,017	21.00
22.00	Skilled Nursing Visit Charges	117,789	15,243	2,160	1,620	136,812	22.00
23.00	Physical Therapy Visits	370	139	17	6	532	23.00
24.00	Physical Therapy Visit Charges	49,859	18,730	2,295	810	71,694	24.00
25.00	Occupational Therapy Visits	157	99	2	6	264	25.00
26.00	Occupational Therapy Visit Charges	21,167	13,358	270	810	35,605	26.00
27.00	Speech Pathology Visits	7	16	1	0	24	27.00
28.00	Speech Pathology Visit Charges	980	2,240	140	0	3,360	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	1	0	0	0	1	31.00
32.00	Home Health Aide Visit Charges	75	0	0	0	75	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,410	368	36	24	1,838	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	189,870	49,571	4,865	3,240	247,546	35.00
36.00	Total Number of Episodes (standard/non outlier)	186		23	2	211	36.00
37.00	Total Number of Outlier Episodes		23		1	24	37.00
38.00	Total Non-Routine Medical Supply Charges	63,039	1,666	785	16	65,506	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1311 | Component CCN: 14-8500 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 11/29/2023 10:22 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			303 NW 11TH STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	FAIRFIELD		IL	62837	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:30	05:00	08:30	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			Y	5	13.00

				Provider name		CCN	
				1.00		2.00	
14.00	RHC/FQHC name, CCN			FAIRFIELD RHC		148500	14.00
14.01				HORIZON HEALTHCARE		148591	14.01
14.02				HORIZON HEALTHCARE GRAYVILLE		148602	14.02
14.03				HORIZON HEALTHCARE CARMI CLINIC		148614	14.03
14.04				FAIRFIELD MEMORIAL HOSPITAL URGENT C		148656	14.04

		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: 14-1311 | Component CCN: 14-8500 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 11/29/2023 10:22 am

RHC I | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County						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	05:00	08:30	05:00	08:30	05:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:30	05:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-10 | Date/Time Prepared: 11/29/2023 10:22 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.306184	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,467,680	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	29,700,182	6.00
7.00	Medicaid cost (line 1 times line 6)	9,093,721	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	3,626,041	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,626,041	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,103,726	0	1,103,726	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	337,943	0	337,943	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	337,943	0	337,943	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,616,153	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	699,887	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,076,748	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,539,405	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,460,570	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,798,513	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,424,554	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/29/2023 10:22 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,737,567	2,737,567	489,517	3,227,084	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		659,745	659,745	0	659,745	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,344,431	5,344,431	0	5,344,431	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,375,069	3,996,554	6,371,623	-81,482	6,290,141	5.00
6.00	00600	MAINTENANCE & REPAIRS	497,567	334,015	831,582	0	831,582	6.00
7.00	00700	OPERATION OF PLANT	0	869,546	869,546	0	869,546	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	560,624	560,624	0	560,624	8.00
9.00	00900	HOUSEKEEPING	703,088	139,061	842,149	0	842,149	9.00
10.00	01000	DIETARY	547,224	429,706	976,930	-615,835	361,095	10.00
11.00	01100	CAFETERIA	0	0	0	615,835	615,835	11.00
13.00	01300	NURSING ADMINISTRATION	423,013	57,705	480,718	0	480,718	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	91,493	58,860	150,353	-52,915	97,438	14.00
15.00	01500	PHARMACY	305,184	1,782,343	2,087,527	-3,080	2,084,447	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	386,322	125,659	511,981	0	511,981	16.00
17.00	01700	SOCIAL SERVICE	137,576	4,439	142,015	0	142,015	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,602,163	878,892	2,481,055	-59,721	2,421,334	30.00
31.00	03100	INTENSIVE CARE UNIT	19,866	5,119	24,985	-4,281	20,704	31.00
44.00	04400	SKILLED NURSING FACILITY	1,129,751	109,506	1,239,257	-7,982	1,231,275	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,228,245	3,296,214	4,524,459	-1,634,668	2,889,791	50.00
53.00	05300	ANESTHESIOLOGY	951,408	72,346	1,023,754	-1,023,754	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	878,312	1,197,163	2,075,475	-104,987	1,970,488	54.00
60.00	06000	LABORATORY	1,096,131	2,298,468	3,394,599	-1,597,013	1,797,586	60.00
65.00	06500	RESPIRATORY THERAPY	225,709	127,951	353,660	-97,918	255,742	65.00
66.00	06600	PHYSICAL THERAPY	800,050	92,446	892,496	-67,729	824,767	66.00
67.00	06700	OCCUPATIONAL THERAPY	214,826	0	214,826	91	214,917	67.00
68.00	06800	SPEECH PATHOLOGY	116,004	0	116,004	4,956	120,960	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	35,146	35,146	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,808,278	2,808,278	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,927,228	1,927,228	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	198,317	119,817	318,134	-100	318,034	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,238,158	669,199	4,907,357	81,482	4,988,839	88.00
90.00	09000	CLINIC	1,932,710	193,501	2,126,211	-65,542	2,060,669	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	PAIN CLINIC	126,802	122,138	248,940	-4	248,936	90.02
90.03	09003	UROLOGY CLINIC	1,012,552	61,456	1,074,008	-32,567	1,041,441	90.03
91.00	09100	EMERGENCY	1,088,386	2,512,436	3,600,822	-86,120	3,514,702	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	361,855	101,425	463,280	62,682	525,962	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		489,517	489,517	-489,517	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,687,781	29,447,849	52,135,630	0	52,135,630	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	66	66	0	66	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	22,687,781	29,447,915	52,135,696	0	52,135,696	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/29/2023 10:22 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-466,320	2,760,764		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	659,745		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-87,981	5,256,450		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,735,421	4,554,720		5.00
6.00	00600	MAINTENANCE & REPAIRS	-12,209	819,373		6.00
7.00	00700	OPERATION OF PLANT	0	869,546		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	560,624		8.00
9.00	00900	HOUSEKEEPING	0	842,149		9.00
10.00	01000	DIETARY	0	361,095		10.00
11.00	01100	CAFETERIA	-242,701	373,134		11.00
13.00	01300	NURSING ADMINISTRATION	0	480,718		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-3,939	93,499		14.00
15.00	01500	PHARMACY	0	2,084,447		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-12,240	499,741		16.00
17.00	01700	SOCIAL SERVICE	0	142,015		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-289,927	2,131,407		30.00
31.00	03100	INTENSIVE CARE UNIT	0	20,704		31.00
44.00	04400	SKILLED NURSING FACILITY	0	1,231,275		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,051,196	1,838,595		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,970,488		54.00
60.00	06000	LABORATORY	0	1,797,586		60.00
65.00	06500	RESPIRATORY THERAPY	0	255,742		65.00
66.00	06600	PHYSICAL THERAPY	0	824,767		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	214,917		67.00
68.00	06800	SPEECH PATHOLOGY	0	120,960		68.00
69.00	06900	ELECTROCARDIOLOGY	-35,146	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,808,278		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,927,228		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	318,034		76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-509,148	4,479,691		88.00
90.00	09000	CLINIC	-1,328,504	732,165		90.00
90.01	09001	WOUND CARE	0	0		90.01
90.02	09002	PAIN CLINIC	0	248,936		90.02
90.03	09003	UROLOGY CLINIC	-820,897	220,544		90.03
91.00	09100	EMERGENCY	-1,883,232	1,631,470		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	525,962		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,478,861	43,656,769		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	66		192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,478,861	43,656,835		200.00

RECLASSIFICATIONS | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/29/2023 10:22 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	344,958	270,877	1.00
	TOTALS		344,958	270,877	
	B - EKG				
1.00	ELECTROCARDIOLOGY	69.00	35,146	0	1.00
	TOTALS		35,146	0	
	C - INTEREST				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	489,517	1.00
	TOTALS		0	489,517	
	D - IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,927,228	1.00
	TOTALS		0	1,927,228	
	E - PT OT ST				
1.00	OCCUPATIONAL THERAPY	67.00	0	15,661	1.00
2.00	SPEECH PATHOLOGY	68.00	0	6,288	2.00
	TOTALS		0	21,949	
	F - HHA THERAPIST				
1.00	HOME HEALTH AGENCY	101.00	62,682	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		62,682	0	
	G - RHC RECRUITING				
1.00	RURAL HEALTH CLINIC	88.00	0	81,482	1.00
	TOTALS		0	81,482	
	H - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,735,506	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	TOTALS		0	4,735,506	
	I - ANESTHESIOLOGY				
1.00	OPERATING ROOM	50.00	951,408	29,056	1.00
	TOTALS		951,408	29,056	
500.00	Grand Total: Increases		1,394,194	7,555,615	500.00

RECLASSIFICATIONS | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/29/2023 10:22 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	344,958	270,877	0		1.00
	TOTALS		344,958	270,877			
	B - EKG						
1.00	RESPIRATORY THERAPY	65.00	0	35,146	0		1.00
	TOTALS		0	35,146			
	C - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	489,517	11		1.00
	TOTALS		0	489,517			
	D - IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,927,228	0		1.00
	TOTALS		0	1,927,228			
	E - PT OT ST						
1.00	PHYSICAL THERAPY	66.00	0	21,949	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	21,949			
	F - HHA THERAPIST						
1.00	PHYSICAL THERAPY	66.00	45,780	0	0		1.00
2.00	OCCUPATIONAL THERAPY	67.00	15,570	0	0		2.00
3.00	SPEECH PATHOLOGY	68.00	1,332	0	0		3.00
	TOTALS		62,682	0			
	G - RHC RECRUITING						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	81,482	0		1.00
	TOTALS		0	81,482			
	H - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	52,915	0		1.00
2.00	PHARMACY	15.00	0	3,080	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	59,721	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	4,281	0		4.00
5.00	SKILLED NURSING FACILITY	44.00	0	7,982	0		5.00
6.00	OPERATING ROOM	50.00	0	2,615,132	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	43,290	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	104,987	0		8.00
9.00	LABORATORY	60.00	0	1,597,013	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	62,772	0		10.00
11.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	100	0		11.00
12.00	CLINIC	90.00	0	65,542	0		12.00
13.00	PAIN CLINIC	90.02	0	4	0		13.00
14.00	UROLOGY CLINIC	90.03	0	32,567	0		14.00
15.00	EMERGENCY	91.00	0	86,120	0		15.00
	TOTALS		0	4,735,506			
	I - ANESTHESIOLOGY						
1.00	ANESTHESIOLOGY	53.00	951,408	29,056	0		1.00
	TOTALS		951,408	29,056			
500.00	Grand Total: Decreases		1,359,048	7,590,761			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 11/29/2023 10:22 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	449,428	0	0	0	424,428	1.00
2.00	Land Improvements	1,087,167	0	0	0	816,960	2.00
3.00	Buildings and Fixtures	25,416,450	0	0	0	23,034,199	3.00
4.00	Building Improvements	25,691,284	0	0	0	25,566,431	4.00
5.00	Fixed Equipment	2,186,470	0	0	0	2,303,877	5.00
6.00	Movable Equipment	14,441,678	0	0	0	9,102,495	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	69,272,477	0	0	0	61,248,390	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	69,272,477	0	0	0	61,248,390	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	25,000	0	1.00
2.00	Land Improvements	270,207	0	2.00
3.00	Buildings and Fixtures	2,382,251	0	3.00
4.00	Building Improvements	124,853	0	4.00
5.00	Fixed Equipment	-117,407	0	5.00
6.00	Movable Equipment	5,339,183	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	8,024,087	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	8,024,087	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 11/29/2023 10:22 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,737,567	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	659,745	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,397,312	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	2,737,567		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	659,745		2.00
3.00	Total (sum of lines 1-2)	0	3,397,312		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part III | Date/Time Prepared: 11/29/2023 10:22 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	2,684,904	0	2,684,904	0.334606	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,339,183	0	5,339,183	0.665394	0	2.00
3.00	Total (sum of lines 1-2)	8,024,087	0	8,024,087	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,293,761	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	659,745	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,953,506	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	467,003	0	0	0	2,760,764	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	659,745	2.00
3.00	Total (sum of lines 1-2)	467,003	0	0	0	3,420,509	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/29/2023 10:22 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	A	-22,514	CAP REL COSTS-BLDG & FIXT	1.00	11	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,319	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-12,209	MAINTENANCE & REPAIRS	6.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,457,494			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-584	ADMINISTRATIVE & GENERAL	5.00	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	-242,701	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-12,240	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/29/2023 10:22 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	RECRUITING	A	-289,454	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	ADVERTISING	A	-253,214	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	PROVIDER TAX	A	-1,091,292	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	DONATIONS	A	-48,325	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	VERIZON RENTAL	A	-286,999	CAP REL COSTS-BLDG & FIXT	1.00	9	33.04
33.05	WAYFAIR RENTAL	A	-150,000	CAP REL COSTS-BLDG & FIXT	1.00	9	33.05
33.06	LOBBYING	A	-14,637	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	OTHER REVENUE	B	-34,596	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	REBATES	B	-3,939	CENTRAL SERVICES & SUPPLY	14.00	0	33.08
33.09	RHC HOSPITALIST	A	-509,148	RURAL HEALTH CLINIC	88.00	0	33.09
33.10	RHC HOSPITALIST BENEFITS	A	-87,981	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	RINARD & WEBER CLINIC	A	-6,807	CAP REL COSTS-BLDG & FIXT	1.00	9	33.11
33.12	ANESTHESIOLOGY EXPENSE	A	-951,408	OPERATING ROOM	50.00	0	33.12
33.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,478,861				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 11/29/2023 10:22 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	54.00	RADIOLOGY-DIAGNOSTIC	MRI	295,503	295,503	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			295,503	295,503	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	G	DSSI	15.00	DSSI	15.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 11/29/2023 10:22 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	10		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	0			5.00

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

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

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

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

6.00	MRI		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 11/29/2023 10:22 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	289,927	289,927	0	0	0	1.00
2.00	50.00	OPERATING ROOM	99,788	99,788	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	35,146	35,146	0	0	0	3.00
4.00	90.00	CLINIC	1,328,504	1,328,504	0	0	0	4.00
5.00	90.03	UROLOGY CLINIC	820,897	820,897	0	0	0	5.00
6.00	91.00	EMERGENCY	2,227,886	1,883,232	344,654	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			4,802,148	4,457,494	344,654		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	90.03	UROLOGY CLINIC	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	289,927		1.00
2.00	50.00	OPERATING ROOM	0	0	0	99,788		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	35,146		3.00
4.00	90.00	CLINIC	0	0	0	1,328,504		4.00
5.00	90.03	UROLOGY CLINIC	0	0	0	820,897		5.00
6.00	91.00	EMERGENCY	0	0	0	1,883,232		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	4,457,494		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/29/2023 10:22 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,760,764	2,760,764				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	659,745		659,745			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,256,450	0	0	5,256,450		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,554,720	419,738	100,306	573,430	5,648,194	5.00
6.00	00600	MAINTENANCE & REPAIRS	819,373	51,090	12,209	120,131	1,002,803	6.00
7.00	00700	OPERATION OF PLANT	869,546	31,324	7,486	0	908,356	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	560,624	21,644	5,172	0	587,440	8.00
9.00	00900	HOUSEKEEPING	842,149	16,280	3,890	169,751	1,032,070	9.00
10.00	01000	DIETARY	361,095	2,217	530	48,834	412,676	10.00
11.00	01100	CAFETERIA	373,134	65,136	15,566	83,286	537,122	11.00
13.00	01300	NURSING ADMINISTRATION	480,718	4,028	962	102,131	587,839	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	93,499	0	0	22,090	115,589	14.00
15.00	01500	PHARMACY	2,084,447	0	0	73,683	2,158,130	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	499,741	24,927	5,957	93,272	623,897	16.00
17.00	01700	SOCIAL SERVICE	142,015	2,708	647	33,216	178,586	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,131,407	322,042	76,959	386,821	2,917,229	30.00
31.00	03100	INTENSIVE CARE UNIT	20,704	22,558	5,391	4,796	53,449	31.00
44.00	04400	SKILLED NURSING FACILITY	1,231,275	267,466	63,917	272,764	1,835,422	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,838,595	232,402	55,538	296,544	2,423,079	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,970,488	77,473	18,514	212,057	2,278,532	54.00
60.00	06000	LABORATORY	1,797,586	43,136	10,308	264,647	2,115,677	60.00
65.00	06500	RESPIRATORY THERAPY	255,742	31,730	7,583	54,495	349,550	65.00
66.00	06600	PHYSICAL THERAPY	824,767	64,121	15,323	182,109	1,086,320	66.00
67.00	06700	OCCUPATIONAL THERAPY	214,917	14,249	3,405	48,108	280,679	67.00
68.00	06800	SPEECH PATHOLOGY	120,960	5,720	1,367	27,686	155,733	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,486	8,486	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,808,278	33,321	7,963	0	2,849,562	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,927,228	0	0	0	1,927,228	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	55,829	13,341	0	69,170	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	318,034	29,361	7,016	47,881	402,292	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,479,691	528,705	126,345	1,023,245	6,157,986	88.00
90.00	09000	CLINIC	732,165	195,104	46,624	466,628	1,440,521	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	PAIN CLINIC	248,936	0	0	30,615	279,551	90.02
90.03	09003	UROLOGY CLINIC	220,544	78,878	18,850	244,468	562,740	90.03
91.00	09100	EMERGENCY	1,631,470	87,085	20,811	262,777	2,002,143	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	525,962	32,492	7,765	102,499	668,718	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,656,769	2,760,764	659,745	5,256,450	43,656,769	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	66	0	0	0	66	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	43,656,835	2,760,764	659,745	5,256,450	43,656,835	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/29/2023 10:22 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,648,194					5.00
6.00	00600	MAINTENANCE & REPAIRS	149,020	1,151,823				6.00
7.00	00700	OPERATION OF PLANT	134,984	15,756	1,059,096			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	87,295	10,887	10,149	695,771		8.00
9.00	00900	HOUSEKEEPING	153,369	8,189	7,634	197,102	1,398,364	9.00
10.00	01000	DIETARY	61,325	1,115	1,040	8,016	1,396	10.00
11.00	01100	CAFETERIA	79,818	32,763	30,543	0	41,016	11.00
13.00	01300	NURSING ADMINISTRATION	87,355	2,026	1,889	0	2,536	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17,177	0	0	0	0	14.00
15.00	01500	PHARMACY	320,705	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	92,713	12,538	11,689	0	15,697	16.00
17.00	01700	SOCIAL SERVICE	26,538	1,362	1,270	0	1,705	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	433,509	161,985	151,010	128,041	202,790	30.00
31.00	03100	INTENSIVE CARE UNIT	7,943	11,347	10,578	0	14,205	31.00
44.00	04400	SKILLED NURSING FACILITY	272,749	134,534	125,419	89,307	168,423	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	360,077	116,897	108,977	96,430	146,343	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	338,597	38,968	36,328	38,758	48,785	54.00
60.00	06000	LABORATORY	314,396	21,697	20,227	9,600	27,163	60.00
65.00	06500	RESPIRATORY THERAPY	51,944	15,960	14,879	5,217	19,981	65.00
66.00	06600	PHYSICAL THERAPY	161,430	32,252	30,067	8,814	40,377	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,710	7,167	6,682	1,953	8,973	67.00
68.00	06800	SPEECH PATHOLOGY	23,142	2,877	2,682	786	3,602	68.00
69.00	06900	ELECTROCARDIOLOGY	1,261	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	423,453	16,760	15,625	0	20,982	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	286,392	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,279	28,081	26,179	0	35,155	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	59,782	14,768	13,768	0	18,489	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	915,090	265,937	247,916	13,209	332,923	88.00
90.00	09000	CLINIC	214,066	98,136	91,487	0	122,857	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	PAIN CLINIC	41,542	0	0	0	0	90.02
90.03	09003	UROLOGY CLINIC	83,625	39,675	36,987	0	49,669	90.03
91.00	09100	EMERGENCY	297,524	43,803	40,835	98,538	54,837	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	99,374	16,343	15,236	0	20,460	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,648,184	1,151,823	1,059,096	695,771	1,398,364	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,648,194	1,151,823	1,059,096	695,771	1,398,364	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/29/2023 10:22 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	485,568					10.00
11.00	01100	CAFETERIA	0	721,262				11.00
13.00	01300	NURSING ADMINISTRATION	0	18,752	700,397			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,381	0	138,147		14.00
15.00	01500	PHARMACY	0	9,536	0	913	2,489,284	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,585	0	240	0	16.00
17.00	01700	SOCIAL SERVICE	0	5,674	0	7	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	122,021	81,055	193,668	1,316	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,968	107	226	20	0	31.00
44.00	04400	SKILLED NURSING FACILITY	358,579	79,110	188,989	1,934	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	52,820	126,225	8,415	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	53,513	0	477	0	54.00
60.00	06000	LABORATORY	0	88,859	0	2,031	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,320	0	309	0	65.00
66.00	06600	PHYSICAL THERAPY	0	31,910	0	787	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,458	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,877	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,184	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	66,572	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	45,689	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,489,284	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	10,734	0	123	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	103,936	0	5,674	0	88.00
90.00	09000	CLINIC	0	37,451	0	1,194	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	PAIN CLINIC	0	8,231	0	15	0	90.02
90.03	09003	UROLOGY CLINIC	0	22,854	0	320	0	90.03
91.00	09100	EMERGENCY	0	62,915	150,334	1,502	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	40,955	607	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	485,568	721,262	700,397	138,145	2,489,284	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	2	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	485,568	721,262	700,397	138,147	2,489,284	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/29/2023 10:22 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	781,359					16.00
17.00	01700	SOCIAL SERVICE	0	215,142				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,394	116,557	4,528,575	0	4,528,575	30.00
31.00	03100	INTENSIVE CARE UNIT	939	0	103,782	0	103,782	31.00
44.00	04400	SKILLED NURSING FACILITY	8,339	98,585	3,361,390	0	3,361,390	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	146,459	0	3,585,722	0	3,585,722	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	170,117	0	3,004,075	0	3,004,075	54.00
60.00	06000	LABORATORY	137,677	0	2,737,327	0	2,737,327	60.00
65.00	06500	RESPIRATORY THERAPY	22,624	0	491,784	0	491,784	65.00
66.00	06600	PHYSICAL THERAPY	19,510	0	1,411,467	0	1,411,467	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,335	0	358,957	0	358,957	67.00
68.00	06800	SPEECH PATHOLOGY	1,741	0	193,440	0	193,440	68.00
69.00	06900	ELECTROCARDIOLOGY	9,782	0	21,713	0	21,713	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	65,097	0	3,458,051	0	3,458,051	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,708	0	2,307,017	0	2,307,017	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,636	0	2,699,784	0	2,699,784	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,886	0	526,842	0	526,842	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	28,488	0	8,071,159	0	8,071,159	88.00
90.00	09000	CLINIC	4,464	0	2,010,176	0	2,010,176	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	PAIN CLINIC	726	0	330,065	0	330,065	90.02
90.03	09003	UROLOGY CLINIC	4,070	0	799,940	0	799,940	90.03
91.00	09100	EMERGENCY	41,367	0	2,793,798	0	2,793,798	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	861,693	0	861,693	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	781,359	215,142	43,656,757	0	43,656,757	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	78	0	78	192.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	781,359	215,142	43,656,835	0	43,656,835	202.00

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		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	419,738	100,306	520,044	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	51,090	12,209	63,299	0	6.00
7.00	00700	OPERATION OF PLANT	0	31,324	7,486	38,810	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,644	5,172	26,816	0	8.00
9.00	00900	HOUSEKEEPING	0	16,280	3,890	20,170	0	9.00
10.00	01000	DIETARY	0	2,217	530	2,747	0	10.00
11.00	01100	CAFETERIA	0	65,136	15,566	80,702	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,028	962	4,990	0	13.00
14.00	01400	CENTRAL SERVICES & 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	24,927	5,957	30,884	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,708	647	3,355	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	322,042	76,959	399,001	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	22,558	5,391	27,949	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	267,466	63,917	331,383	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	232,402	55,538	287,940	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	77,473	18,514	95,987	0	54.00
60.00	06000	LABORATORY	0	43,136	10,308	53,444	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	31,730	7,583	39,313	0	65.00
66.00	06600	PHYSICAL THERAPY	0	64,121	15,323	79,444	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,249	3,405	17,654	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,720	1,367	7,087	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	33,321	7,963	41,284	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	55,829	13,341	69,170	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	29,361	7,016	36,377	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	528,705	126,345	655,050	0	88.00
90.00	09000	CLINIC	0	195,104	46,624	241,728	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	PAIN CLINIC	0	0	0	0	0	90.02
90.03	09003	UROLOGY CLINIC	0	78,878	18,850	97,728	0	90.03
91.00	09100	EMERGENCY	0	87,085	20,811	107,896	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	32,492	7,765	40,257	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,760,764	659,745	3,420,509	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,760,764	659,745	3,420,509	0	202.00

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		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	520,044					5.00
6.00	00600	MAINTENANCE & REPAIRS	13,720	77,019				6.00
7.00	00700	OPERATION OF PLANT	12,428	1,054	52,292			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,037	728	501	36,082		8.00
9.00	00900	HOUSEKEEPING	14,121	548	377	10,221	45,437	9.00
10.00	01000	DIETARY	5,646	75	51	416	45	10.00
11.00	01100	CAFETERIA	7,349	2,191	1,508	0	1,333	11.00
13.00	01300	NURSING ADMINISTRATION	8,043	135	93	0	82	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,581	0	0	0	0	14.00
15.00	01500	PHARMACY	29,528	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,536	838	577	0	510	16.00
17.00	01700	SOCIAL SERVICE	2,443	91	63	0	55	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,914	10,831	7,456	6,640	6,589	30.00
31.00	03100	INTENSIVE CARE UNIT	731	759	522	0	462	31.00
44.00	04400	SKILLED NURSING FACILITY	25,112	8,996	6,192	4,631	5,473	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,153	7,817	5,381	5,001	4,755	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,175	2,606	1,794	2,010	1,585	54.00
60.00	06000	LABORATORY	28,947	1,451	999	498	883	60.00
65.00	06500	RESPIRATORY THERAPY	4,783	1,067	735	271	649	65.00
66.00	06600	PHYSICAL THERAPY	14,863	2,157	1,485	457	1,312	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,840	479	330	101	292	67.00
68.00	06800	SPEECH PATHOLOGY	2,131	192	132	41	117	68.00
69.00	06900	ELECTROCARDIOLOGY	116	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	38,988	1,121	771	0	682	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,368	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	946	1,878	1,293	0	1,142	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,504	988	680	0	601	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	84,265	17,780	12,241	685	10,817	88.00
90.00	09000	CLINIC	19,709	6,562	4,517	0	3,992	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	PAIN CLINIC	3,825	0	0	0	0	90.02
90.03	09003	UROLOGY CLINIC	7,699	2,653	1,826	0	1,614	90.03
91.00	09100	EMERGENCY	27,393	2,929	2,016	5,110	1,782	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	9,149	1,093	752	0	665	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	520,043	77,019	52,292	36,082	45,437	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	520,044	77,019	52,292	36,082	45,437	202.00

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		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	8,980					10.00
11.00	01100	CAFETERIA	0	93,083				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,420	15,763			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	694	0	2,275		14.00
15.00	01500	PHARMACY	0	1,231	0	15	30,774	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,173	0	4	0	16.00
17.00	01700	SOCIAL SERVICE	0	732	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,257	10,461	4,359	22	0	30.00
31.00	03100	INTENSIVE CARE UNIT	92	14	5	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	6,631	10,210	4,253	32	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,817	2,841	138	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,906	0	8	0	54.00
60.00	06000	LABORATORY	0	11,468	0	33	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,461	0	5	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,118	0	13	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	963	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	371	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	282	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,098	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	752	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	30,774	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,385	0	2	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	13,413	0	93	0	88.00
90.00	09000	CLINIC	0	4,833	0	20	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	PAIN CLINIC	0	1,062	0	0	0	90.02
90.03	09003	UROLOGY CLINIC	0	2,949	0	5	0	90.03
91.00	09100	EMERGENCY	0	8,120	3,383	25	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	922	10	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,980	93,083	15,763	2,275	30,774	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,980	93,083	15,763	2,275	30,774	202.00

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		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	44,522					16.00
17.00	01700	SOCIAL SERVICE	0	6,739				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,104	3,651	492,285	0	492,285	30.00
31.00	03100	INTENSIVE CARE UNIT	53	0	30,587	0	30,587	31.00
44.00	04400	SKILLED NURSING FACILITY	474	3,088	406,475	0	406,475	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,333	0	362,176	0	362,176	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,742	0	151,813	0	151,813	54.00
60.00	06000	LABORATORY	7,834	0	105,557	0	105,557	60.00
65.00	06500	RESPIRATORY THERAPY	1,287	0	49,571	0	49,571	65.00
66.00	06600	PHYSICAL THERAPY	1,110	0	104,959	0	104,959	66.00
67.00	06700	OCCUPATIONAL THERAPY	247	0	23,906	0	23,906	67.00
68.00	06800	SPEECH PATHOLOGY	99	0	10,170	0	10,170	68.00
69.00	06900	ELECTROCARDIOLOGY	557	0	955	0	955	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,704	0	87,648	0	87,648	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,715	0	29,835	0	29,835	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,369	0	107,572	0	107,572	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	392	0	45,929	0	45,929	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,621	0	795,965	0	795,965	88.00
90.00	09000	CLINIC	254	0	281,615	0	281,615	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	PAIN CLINIC	41	0	4,928	0	4,928	90.02
90.03	09003	UROLOGY CLINIC	232	0	114,706	0	114,706	90.03
91.00	09100	EMERGENCY	2,354	0	161,008	0	161,008	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	52,848	0	52,848	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,522	6,739	3,420,508	0	3,420,508	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1	0	1	192.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	44,522	6,739	3,420,509	0	3,420,509	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/29/2023 10:22 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	163,138					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		163,138				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	21,771,519			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,803	24,803	2,375,069	-5,648,194	38,008,641	5.00
6.00	00600	MAINTENANCE & REPAIRS	3,019	3,019	497,567	0	1,002,803	6.00
7.00	00700	OPERATION OF PLANT	1,851	1,851	0	0	908,356	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,279	1,279	0	0	587,440	8.00
9.00	00900	HOUSEKEEPING	962	962	703,088	0	1,032,070	9.00
10.00	01000	DIETARY	131	131	202,266	0	412,676	10.00
11.00	01100	CAFETERIA	3,849	3,849	344,958	0	537,122	11.00
13.00	01300	NURSING ADMINISTRATION	238	238	423,013	0	587,839	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	91,493	0	115,589	14.00
15.00	01500	PHARMACY	0	0	305,184	0	2,158,130	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,473	1,473	386,322	0	623,897	16.00
17.00	01700	SOCIAL SERVICE	160	160	137,576	0	178,586	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,030	19,030	1,602,163	0	2,917,229	30.00
31.00	03100	INTENSIVE CARE UNIT	1,333	1,333	19,866	0	53,449	31.00
44.00	04400	SKILLED NURSING FACILITY	15,805	15,805	1,129,751	0	1,835,422	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,733	13,733	1,228,245	0	2,423,079	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,578	4,578	878,312	0	2,278,532	54.00
60.00	06000	LABORATORY	2,549	2,549	1,096,131	0	2,115,677	60.00
65.00	06500	RESPIRATORY THERAPY	1,875	1,875	225,709	0	349,550	65.00
66.00	06600	PHYSICAL THERAPY	3,789	3,789	754,270	0	1,086,320	66.00
67.00	06700	OCCUPATIONAL THERAPY	842	842	199,256	0	280,679	67.00
68.00	06800	SPEECH PATHOLOGY	338	338	114,672	0	155,733	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	35,146	0	8,486	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,969	1,969	0	0	2,849,562	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,927,228	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,299	3,299	0	0	69,170	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,735	1,735	198,317	0	402,292	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	31,242	31,242	4,238,158	0	6,157,986	88.00
90.00	09000	CLINIC	11,529	11,529	1,932,710	0	1,440,521	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	PAIN CLINIC	0	0	126,802	0	279,551	90.02
90.03	09003	UROLOGY CLINIC	4,661	4,661	1,012,552	0	562,740	90.03
91.00	09100	EMERGENCY	5,146	5,146	1,088,386	0	2,002,143	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	1,920	1,920	424,537	0	668,718	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	163,138	163,138	21,771,519	-5,648,194	38,008,575	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	66	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,760,764	659,745	5,256,450		5,648,194	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.922875	4.044092	0.241437		0.148603	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		520,044	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.013682	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: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/29/2023 10:22 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	135,316					6.00
7.00	00700	OPERATION OF PLANT	1,851	133,465				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,279	1,279	58,415			8.00
9.00	00900	HOUSEKEEPING	962	962	16,548	131,224		9.00
10.00	01000	DIETARY	131	131	673	131	38,023	10.00
11.00	01100	CAFETERIA	3,849	3,849	0	3,849	0	11.00
13.00	01300	NURSING ADMINISTRATION	238	238	0	238	0	13.00
14.00	01400	CENTRAL SERVICES & 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	1,473	1,473	0	1,473	0	16.00
17.00	01700	SOCIAL SERVICE	160	160	0	160	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,030	19,030	10,750	19,030	9,555	30.00
31.00	03100	INTENSIVE CARE UNIT	1,333	1,333	0	1,333	389	31.00
44.00	04400	SKILLED NURSING FACILITY	15,805	15,805	7,498	15,805	28,079	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,733	13,733	8,096	13,733	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,578	4,578	3,254	4,578	0	54.00
60.00	06000	LABORATORY	2,549	2,549	806	2,549	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,875	1,875	438	1,875	0	65.00
66.00	06600	PHYSICAL THERAPY	3,789	3,789	740	3,789	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	842	842	164	842	0	67.00
68.00	06800	SPEECH PATHOLOGY	338	338	66	338	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,969	1,969	0	1,969	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	3,299	3,299	0	3,299	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,735	1,735	0	1,735	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	31,242	31,242	1,109	31,242	0	88.00
90.00	09000	CLINIC	11,529	11,529	0	11,529	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	PAIN CLINIC	0	0	0	0	0	90.02
90.03	09003	UROLOGY CLINIC	4,661	4,661	0	4,661	0	90.03
91.00	09100	EMERGENCY	5,146	5,146	8,273	5,146	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	1,920	1,920	0	1,920	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	135,316	133,465	58,415	131,224	38,023	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,151,823	1,059,096	695,771	1,398,364	485,568	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.512098	7.935384	11.910828	10.656313	12.770376	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	77,019	52,292	36,082	45,437	8,980	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.569179	0.391803	0.617684	0.346255	0.236173	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: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/29/2023 10:22 am

		Cost Center Description	CAFETERIA (FTES SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	27,078					11.00
13.00	01300	NURSING ADMINISTRATION	704	228,921				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	202	0	5,827,341			14.00
15.00	01500	PHARMACY	358	0	38,503	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	923	0	10,126	0	142,043,175	16.00
17.00	01700	SOCIAL SERVICE	213	0	283	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,043	63,299	55,518	0	3,525,567	30.00
31.00	03100	INTENSIVE CARE UNIT	4	74	838	0	170,700	31.00
44.00	04400	SKILLED NURSING FACILITY	2,970	61,770	81,570	0	1,515,819	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,983	41,256	354,951	0	26,624,053	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,009	0	20,107	0	30,928,751	54.00
60.00	06000	LABORATORY	3,336	0	85,681	0	25,027,541	60.00
65.00	06500	RESPIRATORY THERAPY	425	0	13,022	0	4,112,750	65.00
66.00	06600	PHYSICAL THERAPY	1,198	0	33,199	0	3,546,652	66.00
67.00	06700	OCCUPATIONAL THERAPY	280	0	0	0	788,063	67.00
68.00	06800	SPEECH PATHOLOGY	108	0	0	0	316,432	68.00
69.00	06900	ELECTROCARDIOLOGY	82	0	0	0	1,778,303	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,808,278	0	11,833,721	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,927,228	0	8,672,524	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	7,568,785	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	403	0	5,171	0	1,251,705	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,902	0	239,328	0	5,178,758	88.00
90.00	09000	CLINIC	1,406	0	50,355	0	811,418	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	PAIN CLINIC	309	0	625	0	131,922	90.02
90.03	09003	UROLOGY CLINIC	858	0	13,517	0	739,858	90.03
91.00	09100	EMERGENCY	2,362	49,136	63,363	0	7,519,853	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	13,386	25,612	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,078	228,921	5,827,275	100	142,043,175	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	66	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	721,262	700,397	138,147	2,489,284	781,359	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.636458	3.059558	0.023707	24,892.840000	0.005501	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	93,083	15,763	2,275	30,774	44,522	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.437588	0.068858	0.000390	307.740000	0.000313	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: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/29/2023 10:22 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)		
			17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	2,047		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	1,109		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
44.00	04400	SKILLED NURSING FACILITY	938		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		77.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0		88.00
90.00	09000	CLINIC	0		90.00
90.01	09001	WOUND CARE	0		90.01
90.02	09002	PAIN CLINIC	0		90.02
90.03	09003	UROLOGY CLINIC	0		90.03
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		93.99
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
101.00	10100	HOME HEALTH AGENCY	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,047		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	215,142		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	105.101124		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,739		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.292135		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: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/29/2023 10:22 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	4,528,575		4,528,575	0	4,528,575	30.00
31.00	03100	INTENSIVE CARE UNIT	103,782		103,782	0	103,782	31.00
44.00	04400	SKILLED NURSING FACILITY	3,361,390		3,361,390	0	3,361,390	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,585,722		3,585,722	0	3,585,722	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,004,075		3,004,075	0	3,004,075	54.00
60.00	06000	LABORATORY	2,737,327		2,737,327	0	2,737,327	60.00
65.00	06500	RESPIRATORY THERAPY	491,784	0	491,784	0	491,784	65.00
66.00	06600	PHYSICAL THERAPY	1,411,467	0	1,411,467	0	1,411,467	66.00
67.00	06700	OCCUPATIONAL THERAPY	358,957	0	358,957	0	358,957	67.00
68.00	06800	SPEECH PATHOLOGY	193,440	0	193,440	0	193,440	68.00
69.00	06900	ELECTROCARDIOLOGY	21,713		21,713	0	21,713	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,458,051		3,458,051	0	3,458,051	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,307,017		2,307,017	0	2,307,017	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,699,784		2,699,784	0	2,699,784	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	526,842		526,842	0	526,842	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,071,159		8,071,159	0	8,071,159	88.00
90.00	09000	CLINIC	2,010,176		2,010,176	0	2,010,176	90.00
90.01	09001	WOUND CARE	0		0	0	0	90.01
90.02	09002	PAIN CLINIC	330,065		330,065	0	330,065	90.02
90.03	09003	UROLOGY CLINIC	799,940		799,940	0	799,940	90.03
91.00	09100	EMERGENCY	2,793,798		2,793,798	0	2,793,798	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,394,086		1,394,086		1,394,086	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	861,693		861,693		861,693	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	45,050,843	0	45,050,843	0	45,050,843	200.00
201.00		Less Observation Beds	1,394,086		1,394,086		1,394,086	201.00
202.00		Total (see instructions)	43,656,757	0	43,656,757	0	43,656,757	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/29/2023 10:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,026,496		2,026,496			30.00
31.00	03100	INTENSIVE CARE UNIT	170,700		170,700			31.00
44.00	04400	SKILLED NURSING FACILITY	1,515,819		1,515,819			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,120,966	24,503,087	26,624,053	0.134680	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,120,554	29,808,197	30,928,751	0.097129	0.000000	54.00
60.00	06000	LABORATORY	1,782,576	23,244,965	25,027,541	0.109373	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,470,773	2,641,977	4,112,750	0.119575	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	475,078	3,071,574	3,546,652	0.397972	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	495,854	292,209	788,063	0.455493	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	93,504	222,928	316,432	0.611316	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	170,146	1,608,157	1,778,303	0.012210	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,458,643	10,375,078	11,833,721	0.292220	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,019,649	7,652,875	8,672,524	0.266014	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,743,878	5,824,907	7,568,785	0.356700	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,251,705	1,251,705	0.420899	0.000000	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,178,758	5,178,758			88.00
90.00	09000	CLINIC	760	810,658	811,418	2.477362	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	0.000000	0.000000	90.01
90.02	09002	PAIN CLINIC	0	131,922	131,922	2.501971	0.000000	90.02
90.03	09003	UROLOGY CLINIC	0	739,858	739,858	1.081207	0.000000	90.03
91.00	09100	EMERGENCY	144,656	7,375,197	7,519,853	0.371523	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	24,520	1,474,551	1,499,071	0.929967	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	540,033	540,033			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	15,834,572	126,748,636	142,583,208			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,834,572	126,748,636	142,583,208			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/29/2023 10:22 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
31.00	03100	INTENSIVE CARE UNIT		31.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.134680	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097129	54.00
60.00	06000	LABORATORY	0.109373	60.00
65.00	06500	RESPIRATORY THERAPY	0.119575	65.00
66.00	06600	PHYSICAL THERAPY	0.397972	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.455493	67.00
68.00	06800	SPEECH PATHOLOGY	0.611316	68.00
69.00	06900	ELECTROCARDIOLOGY	0.012210	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.292220	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.266014	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.356700	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.420899	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	2.477362	90.00
90.01	09001	WOUND CARE	0.000000	90.01
90.02	09002	PAIN CLINIC	2.501971	90.02
90.03	09003	UROLOGY CLINIC	1.081207	90.03
91.00	09100	EMERGENCY	0.371523	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.929967	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	93.99
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		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: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/29/2023 10:22 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	4,528,575		4,528,575	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	103,782		103,782	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	3,361,390		3,361,390	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,585,722		3,585,722	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,004,075		3,004,075	0	0	54.00
60.00	06000	LABORATORY	2,737,327		2,737,327	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	491,784	0	491,784	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,411,467	0	1,411,467	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	358,957	0	358,957	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	193,440	0	193,440	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	21,713		21,713	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,458,051		3,458,051	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,307,017		2,307,017	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,699,784		2,699,784	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	526,842		526,842	0	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,071,159		8,071,159	0	0	88.00
90.00	09000	CLINIC	2,010,176		2,010,176	0	0	90.00
90.01	09001	WOUND CARE	0		0	0	0	90.01
90.02	09002	PAIN CLINIC	330,065		330,065	0	0	90.02
90.03	09003	UROLOGY CLINIC	799,940		799,940	0	0	90.03
91.00	09100	EMERGENCY	2,793,798		2,793,798	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,394,086		1,394,086		0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	861,693		861,693		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	45,050,843	0	45,050,843	0	0	200.00
201.00		Less Observation Beds	1,394,086		1,394,086		0	201.00
202.00		Total (see instructions)	43,656,757	0	43,656,757	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I | Date/Time Prepared: 11/29/2023 10:22 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	0		0			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	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	0	0	0	0.000000	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	0	0	0	0.000000	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0.000000	0.000000	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	0.000000	0.000000	90.01
90.02	09002	PAIN CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	UROLOGY CLINIC	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	0	0	0			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	0	0	0			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/29/2023 10:22 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
31.00	03100	INTENSIVE CARE UNIT		31.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CARE	0.000000	90.01
90.02	09002	PAIN CLINIC	0.000000	90.02
90.03	09003	UROLOGY CLINIC	0.000000	90.03
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	93.99
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		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: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 11/29/2023 10:22 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	362,176	26,624,053	0.013603	956,675	13,014	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	151,813	30,928,751	0.004908	563,234	2,764	54.00
60.00	06000	LABORATORY	105,557	25,027,541	0.004218	951,584	4,014	60.00
65.00	06500	RESPIRATORY THERAPY	49,571	4,112,750	0.012053	858,603	10,349	65.00
66.00	06600	PHYSICAL THERAPY	104,959	3,546,652	0.029594	82,980	2,456	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,906	788,063	0.030335	63,166	1,916	67.00
68.00	06800	SPEECH PATHOLOGY	10,170	316,432	0.032140	35,927	1,155	68.00
69.00	06900	ELECTROCARDIOLOGY	955	1,778,303	0.000537	84,262	45	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	87,648	11,833,721	0.007407	842,292	6,239	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,835	8,672,524	0.003440	853,563	2,936	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,572	7,568,785	0.014213	835,701	11,878	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	45,929	1,251,705	0.036693	0	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	795,965	5,178,758	0.153698	0	0	88.00
90.00	09000	CLINIC	281,615	811,418	0.347065	0	0	90.00
90.01	09001	WOUND CARE	0	0	0.000000	0	0	90.01
90.02	09002	PAIN CLINIC	4,928	131,922	0.037355	0	0	90.02
90.03	09003	UROLOGY CLINIC	114,706	739,858	0.155038	0	0	90.03
91.00	09100	EMERGENCY	161,008	7,519,853	0.021411	30,458	652	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	151,546	1,499,071	0.101093	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,589,859	138,330,160		6,158,445	57,418	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/29/2023 10:22 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	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	PAIN CLINIC	0	0	0	0	0	90.02
90.03	09003	UROLOGY CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/29/2023 10:22 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	26,624,053	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	30,928,751	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	25,027,541	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,112,750	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,546,652	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	788,063	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	316,432	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,778,303	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,833,721	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,672,524	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,568,785	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,251,705	0.000000	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,178,758	0.000000	88.00
90.00	09000	CLINIC	0	0	0	811,418	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	0	0.000000	90.01
90.02	09002	PAIN CLINIC	0	0	0	131,922	0.000000	90.02
90.03	09003	UROLOGY CLINIC	0	0	0	739,858	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	7,519,853	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,499,071	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	138,330,160		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/29/2023 10:22 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	956,675	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	563,234	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	951,584	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	858,603	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	82,980	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	63,166	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	35,927	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	84,262	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	842,292	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	853,563	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	835,701	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	0	0	90.01
90.02	09002	PAIN CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	UROLOGY CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	30,458	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		6,158,445	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/29/2023 10:22 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	0.134680	0	7,692,919	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097129	0	11,290,637	0	0	54.00
60.00	06000	LABORATORY	0.109373	0	8,738,809	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.119575	0	976,974	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.397972	0	1,242,408	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.455493	0	56,405	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.611316	0	28,768	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.012210	0	782,090	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.292220	0	3,813,723	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.266014	0	2,685,300	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.356700	0	2,663,393	2,431	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.420899	0	708,179	0	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	2.477362	0	307,343	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	0	0	90.01
90.02	09002	PAIN CLINIC	2.501971	0	57,051	0	0	90.02
90.03	09003	UROLOGY CLINIC	1.081207	0	329,251	0	0	90.03
91.00	09100	EMERGENCY	0.371523	0	2,433,539	663	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.929967	0	593,721	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	44,400,510	3,094	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	44,400,510	3,094	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/29/2023 10:22 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	1,036,082	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,096,648	0		54.00
60.00	06000	LABORATORY	955,790	0		60.00
65.00	06500	RESPIRATORY THERAPY	116,822	0		65.00
66.00	06600	PHYSICAL THERAPY	494,444	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	25,692	0		67.00
68.00	06800	SPEECH PATHOLOGY	17,586	0		68.00
69.00	06900	ELECTROCARDIOLOGY	9,549	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,114,446	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	714,327	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	950,032	867		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	298,072	0		76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	761,400	0		90.00
90.01	09001	WOUND CARE	0	0		90.01
90.02	09002	PAIN CLINIC	142,740	0		90.02
90.03	09003	UROLOGY CLINIC	355,988	0		90.03
91.00	09100	EMERGENCY	904,116	246		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	552,141	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	9,545,875	1,113		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	9,545,875	1,113		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1311 | Component CCN: 14-5552 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/29/2023 10:22 am

Title XVIII | Skilled Nursing Facility | PPS

		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	0.134680	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097129	0	0	0	0	54.00
60.00	06000	LABORATORY	0.109373	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.119575	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.397972	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.455493	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.611316	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.012210	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.292220	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.266014	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.356700	0	0	2,307	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.420899	0	0	0	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	2.477362	0	0	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	0	0	90.01
90.02	09002	PAIN CLINIC	2.501971	0	0	0	0	90.02
90.03	09003	UROLOGY CLINIC	1.081207	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.371523	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.929967	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	2,307	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	2,307	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1311 | Component CCN: 14-5552 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V | Date/Time Prepared: 11/29/2023 10:22 am

Title XVIII | Skilled Nursing Facility | PPS

		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
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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	823		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CARE	0	0		90.01
90.02	09002	PAIN CLINIC	0	0		90.02
90.03	09003	UROLOGY CLINIC	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	823		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	823		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part I Date/Time Prepared: 11/29/2023 10:22 am

Title XIX | Hospital | Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	492,285	0	492,285	2,576	191.10	30.00
31.00	INTENSIVE CARE UNIT	30,587		30,587	105	291.30	31.00
44.00	SKILLED NURSING FACILITY	406,475		406,475	7,570	53.70	44.00
200.00	Total (lines 30 through 199)	929,347		929,347	10,251		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	11	2,102	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	11	2,102	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 11/29/2023 10:22 am

Title XIX | 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	362,176	0	0.000000	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	151,813	0	0.000000	0	0	54.00
60.00	06000	LABORATORY	105,557	0	0.000000	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	49,571	0	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	104,959	0	0.000000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,906	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,170	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	955	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	87,648	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,835	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,572	0	0.000000	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	45,929	0	0.000000	0	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	795,965	0	0.000000	0	0	88.00
90.00	09000	CLINIC	281,615	0	0.000000	0	0	90.00
90.01	09001	WOUND CARE	0	0	0.000000	0	0	90.01
90.02	09002	PAIN CLINIC	4,928	0	0.000000	0	0	90.02
90.03	09003	UROLOGY CLINIC	114,706	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	161,008	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	151,546	0	0.000000	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,589,859	0		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part III Date/Time Prepared: 11/29/2023 10:22 am

Title XIX | Hospital | Cost

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,576	0.00	11	30.00
31.00	03100	INTENSIVE CARE UNIT		0	105	0.00	0	31.00
44.00	04400	SKILLED NURSING FACILITY		0	7,570	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	10,251		11	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/29/2023 10:22 am

Title XIX | 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	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
90.02	09002	PAIN CLINIC	0	0	0	0	0	90.02
90.03	09003	UROLOGY CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/29/2023 10:22 am

Title XIX | 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	0	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	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	0	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	0	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0.000000	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	0	0.000000	90.01
90.02	09002	PAIN CLINIC	0	0	0	0	0.000000	90.02
90.03	09003	UROLOGY CLINIC	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/29/2023 10:22 am

Title XIX | 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	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
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
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
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	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	0	0	90.01
90.02	09002	PAIN CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	UROLOGY CLINIC	0.000000	0	0	0	0	90.03
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
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/29/2023 10:22 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)	2,576	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,576	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,783	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)	1,113	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)	4,528,575	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)	4,528,575	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,528,575	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)	1,757.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,956,643	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)	1,956,643	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/29/2023 10:22 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	103,782	105	988.40	42	41,513	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,257,690	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	3,255,846	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	793	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,757.99	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/29/2023 10:22 am

Title XVIII | Hospital | Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,394,086	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	492,285	4,528,575	0.108706	1,394,086	151,546	90.00
91.00	Nursing Program cost	0	4,528,575	0.000000	1,394,086	0	91.00
92.00	Allied health cost	0	4,528,575	0.000000	1,394,086	0	92.00
93.00	All other Medical Education	0	4,528,575	0.000000	1,394,086	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1311 Component CCN: 14-5552	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/29/2023 10:22 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)	7,570	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,570	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)	7,570	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)	1,108	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)	3,361,390	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)	3,361,390	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)	3,361,390	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: 14-1311 | Component CCN: 14-5552 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/29/2023 10:22 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)	3,361,390	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	444.04	71.00
72.00	Program routine service cost (line 9 x line 71)	491,996	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)	491,996	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)	491,996	83.00
84.00	Program inpatient ancillary services (see instructions)	381,265	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)	873,261	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: 14-1311 Component CCN: 14-5552	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/29/2023 10:22 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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/29/2023 10:22 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,576	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,576	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,783	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)	11	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	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)	4,528,575	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)	4,528,575	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,528,575	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)	1,757.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	19,338	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)	19,338	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/29/2023 10:22 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	103,782	105	988.40	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	19,338	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	793	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,757.99	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/29/2023 10:22 am

Title XIX | Hospital | Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,394,086	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	492,285	4,528,575	0.108706	1,394,086	151,546	90.00
91.00	Nursing Program cost	0	4,528,575	0.000000	1,394,086	0	91.00
92.00	Allied health cost	0	4,528,575	0.000000	1,394,086	0	92.00
93.00	All other Medical Education	0	4,528,575	0.000000	1,394,086	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/29/2023 10:22 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		1,671,438		30.00
31.00	03100	INTENSIVE CARE UNIT		103,916		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.134680	956,675	128,845	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097129	563,234	54,706	54.00
60.00	06000	LABORATORY	0.109373	951,584	104,078	60.00
65.00	06500	RESPIRATORY THERAPY	0.119575	858,603	102,667	65.00
66.00	06600	PHYSICAL THERAPY	0.397972	82,980	33,024	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.455493	63,166	28,772	67.00
68.00	06800	SPEECH PATHOLOGY	0.611316	35,927	21,963	68.00
69.00	06900	ELECTROCARDIOLOGY	0.012210	84,262	1,029	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.292220	842,292	246,135	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.266014	853,563	227,060	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.356700	835,701	298,095	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.420899	0	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	2.477362	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	90.01
90.02	09002	PAIN CLINIC	2.501971	0	0	90.02
90.03	09003	UROLOGY CLINIC	1.081207	0	0	90.03
91.00	09100	EMERGENCY	0.371523	30,458	11,316	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.929967	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,158,445	1,257,690	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)		6,158,445		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1311 | Component CCN: 14-5552 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/29/2023 10:22 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
31.00	03100	INTENSIVE CARE UNIT				31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.134680	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097129	9,321	905	54.00
60.00	06000	LABORATORY	0.109373	58,279	6,374	60.00
65.00	06500	RESPIRATORY THERAPY	0.119575	74,470	8,905	65.00
66.00	06600	PHYSICAL THERAPY	0.397972	260,791	103,788	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.455493	303,357	138,177	67.00
68.00	06800	SPEECH PATHOLOGY	0.611316	41,693	25,488	68.00
69.00	06900	ELECTROCARDIOLOGY	0.012210	2,724	33	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.292220	25,247	7,378	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.266014	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.356700	252,922	90,217	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.420899	0	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	2.477362	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	90.01
90.02	09002	PAIN CLINIC	2.501971	0	0	90.02
90.03	09003	UROLOGY CLINIC	1.081207	0	0	90.03
91.00	09100	EMERGENCY	0.371523	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.929967	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,028,804	381,265	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)		1,028,804		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/29/2023 10:22 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	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	0.000000	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	90.01
90.02	09002	PAIN CLINIC	0.000000	0	0	90.02
90.03	09003	UROLOGY CLINIC	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
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: 14-1311	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/29/2023 10:22 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,546,988	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	9,546,988	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	9,642,458	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)	127,304	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	6,962,171	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,552,983	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)	2,552,983	30.00
31.00	Primary payer payments	994	31.00
32.00	Subtotal (line 30 minus line 31)	2,551,989	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)	953,792	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	619,965	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	739,248	36.00
37.00	Subtotal (see instructions)	3,171,954	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)	3,171,954	40.00
40.01	Sequestration adjustment (see instructions)	63,439	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	3,523,929	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)	-415,414	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	333,827	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: 14-1311	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/29/2023 10:22 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: 14-1311 Component CCN: 14-5552	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/29/2023 10:22 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	823	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)	823	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	2,307	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)	2,307	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)	2,307	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,484	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)	823	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)	823	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)	823	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	823	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)	823	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)	823	40.00
40.01	Sequestration adjustment (see instructions)	16	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	701	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)	106	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: 14-1311 Component CCN: 14-5552	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/29/2023 10:22 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: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I Date/Time Prepared: 11/29/2023 10:22 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		2,409,067		3,523,929	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)		2,409,067		3,523,929	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		411,909		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		415,414	6.02
7.00	Total Medicare program liability (see instructions)		2,820,976		3,108,515	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: 14-1311 | Component CCN: 14-5552 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/29/2023 10:22 am

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		516,432		701	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)		516,432		701	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		1		106	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		516,433		807	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: 14-1311	Period: From 07/01/2022 To 06/30/2023	Worksheet E-1 Part II Date/Time Prepared: 11/29/2023 10:22 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	Provider CCN: 14-1311	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part V Date/Time Prepared: 11/29/2023 10:22 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,255,846	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	3,255,846	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,288,404	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,288,404	19.00
20.00	Deductibles (exclude professional component)	421,799	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,866,605	22.00
23.00	Coinsurance	21,138	23.00
24.00	Subtotal (line 22 minus line 23)	2,845,467	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	50,892	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	33,080	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	20,996	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,878,547	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)	2,878,547	30.00
30.01	Sequestration adjustment (see instructions)	57,571	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,409,067	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)	411,909	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	17,812	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1311 Component CCN: 14-5552	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part VI Date/Time Prepared: 11/29/2023 10:22 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)	610,799	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)	610,799	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	83,827	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)	526,972	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	526,972	15.00
15.01	Sequestration adjustment (see instructions)	10,539	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	516,432	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)	1	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: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G | Date/Time Prepared: 11/29/2023 10:22 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	-6,402,055	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	8,574,767	0	0	0	4.00
5.00	Other receivable	1,049,034	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,396,101	0	0	0	6.00
7.00	Inventory	59,837	0	0	0	7.00
8.00	Prepaid expenses	149,839	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)	-964,679	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	25,000	0	0	0	12.00
13.00	Land improvements	270,207	0	0	0	13.00
14.00	Accumulated depreciation	-86,350	0	0	0	14.00
15.00	Buildings	2,382,251	0	0	0	15.00
16.00	Accumulated depreciation	-1,374,445	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	-117,407	0	0	0	19.00
20.00	Accumulated depreciation	-69,407	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	5,339,183	0	0	0	23.00
24.00	Accumulated depreciation	-1,157,185	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	-20	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	124,853	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	5,336,680	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	-1,109,019	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-1,109,019	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	3,262,982	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	499,421	0	0	0	37.00
38.00	Salaries, wages, and fees payable	132,999	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	-213,827	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	-1	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	418,592	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	-374,653	0	0	0	46.00
47.00	Notes payable	3,333,561	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,958,908	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,377,500	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-114,518				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)	-114,518	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	3,262,982	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-1 | Date/Time Prepared: 11/29/2023 10:22 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		1		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-114,519				2.00
3.00	Total (sum of line 1 and line 2)		-114,518		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-114,518		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)		-114,518		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/29/2023 10:22 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,675,745		3,675,745	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,515,819		1,515,819	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,191,564		5,191,564	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	170,700		170,700	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)	170,700		170,700	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,362,264		5,362,264	17.00
18.00	Ancillary services	12,744,768	132,095,389	144,840,157	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	5,178,758	5,178,758	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		540,033	540,033	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	18,107,032	137,814,180	155,921,212	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		52,135,696		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		52,135,696		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1311 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-3 | Date/Time Prepared: 11/29/2023 10:22 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	155,921,212	1.00
2.00	Less contractual allowances and discounts on patients' accounts	105,086,624	2.00
3.00	Net patient revenues (line 1 minus line 2)	50,834,588	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	52,135,696	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,301,108	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	304,586	6.00
7.00	Income from investments	22,514	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	-7,145	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	242,701	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	12,240	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	584	21.00
22.00	Rental of hospital space	436,999	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	174,110	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,186,589	25.00
26.00	Total (line 5 plus line 25)	-114,519	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-114,519	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1311 | HHA CCN: 14-7612 | Period: From 07/01/2022 To 06/30/2023 | Worksheet H | Date/Time Prepared: 11/29/2023 10:22 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	106,681	0	35,455	0	40,358	182,494	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	255,174	0	0	0	0	255,174	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	25,612	25,612	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	361,855	0	35,455	0	65,970	463,280	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	182,494	0	182,494			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	255,174	0	255,174			6.00
7.00	Physical Therapy	45,780	45,780	0	45,780			7.00
8.00	Occupational Therapy	15,570	15,570	0	15,570			8.00
9.00	Speech Pathology	1,332	1,332	0	1,332			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	0	0	0			11.00
12.00	Supplies (see instructions)	0	25,612	0	25,612			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	62,682	525,962	0	525,962			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 14-1311 | HHA CCN: 14-7612 | Period: From 07/01/2022 To 06/30/2023 | Worksheet H-1 Part I | Date/Time Prepared: 11/29/2023 10:22 am

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	182,494	0	0	0	0	182,494	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	255,174	0	0	0	0	255,174	6.00
7.00	Physical Therapy	45,780	0	0	0	0	45,780	7.00
8.00	Occupational Therapy	15,570	0	0	0	0	15,570	8.00
9.00	Speech Pathology	1,332	0	0	0	0	1,332	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	25,612	0	0	0	0	25,612	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	525,962	0	0	0	0	525,962	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	182,494			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	135,581	390,755		6.00
7.00	Physical Therapy	24,324	70,104		7.00
8.00	Occupational Therapy	8,273	23,843		8.00
9.00	Speech Pathology	708	2,040		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Home Health Aide	0	0		11.00
12.00	Supplies (see instructions)	13,608	39,220		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		525,962		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-1311 | HHA CCN: 14-7612 | Period: From 07/01/2022 To 06/30/2023 | Worksheet H-1 Part II | Date/Time Prepared: 11/29/2023 10:22 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-182,494	343,468	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	255,174	6.00
7.00	Physical Therapy	0	0	0	0	0	45,780	7.00
8.00	Occupational Therapy	0	0	0	0	0	15,570	8.00
9.00	Speech Pathology	0	0	0	0	0	1,332	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	25,612	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-182,494	343,468	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		182,494	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.531328	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1311 | HHA CCN: 14-7612 | Period: From 07/01/2022 To 06/30/2023 | Worksheet H-2 Part I | Date/Time Prepared: 11/29/2023 10:22 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	32,492	7,765	25,757	66,014	9,810	1.00
2.00	Skilled Nursing Care	390,755	0	0	61,608	452,363	67,223	2.00
3.00	Physical Therapy	70,104	0	0	11,053	81,157	12,060	3.00
4.00	Occupational Therapy	23,843	0	0	3,759	27,602	4,102	4.00
5.00	Speech Pathology	2,040	0	0	322	2,362	351	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	39,220	0	0	0	39,220	5,828	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	525,962	32,492	7,765	102,499	668,718	99,374	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	16,343	15,236	0	20,460	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	16,343	15,236	0	20,460	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1311 | HHA CCN: 14-7612 | Period: From 07/01/2022 To 06/30/2023 | Worksheet H-2 Part I | Date/Time Prepared: 11/29/2023 10:22 am

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	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		13.00	14.00	15.00	16.00	17.00	24.00	
1.00	Administrative and General	40,955	607	0	0	0	169,425	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	519,586	2.00
3.00	Physical Therapy	0	0	0	0	0	93,217	3.00
4.00	Occupational Therapy	0	0	0	0	0	31,704	4.00
5.00	Speech Pathology	0	0	0	0	0	2,713	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	45,048	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	40,955	607	0	0	0	861,693	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	169,425					1.00
2.00	Skilled Nursing Care	0	519,586	127,163	646,749			2.00
3.00	Physical Therapy	0	93,217	22,814	116,031			3.00
4.00	Occupational Therapy	0	31,704	7,759	39,463			4.00
5.00	Speech Pathology	0	2,713	664	3,377			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	45,048	11,025	56,073			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	0	861,693	169,425	861,693			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.244739				21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1311 | HHA CCN: 14-7612 | Period: From 07/01/2022 To 06/30/2023 | Worksheet H-2 Part II | Date/Time Prepared: 11/29/2023 10:22 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	1,920	1,920	106,681	0	66,014	1,920	1.00
2.00	Skilled Nursing Care	0	0	255,174	0	452,363	0	2.00
3.00	Physical Therapy	0	0	45,780	0	81,157	0	3.00
4.00	Occupational Therapy	0	0	15,570	0	27,602	0	4.00
5.00	Speech Pathology	0	0	1,332	0	2,362	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	39,220	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,920	1,920	424,537		668,718	1,920	20.00
21.00	Total cost to be allocated	32,492	7,765	102,499		99,374	16,343	21.00
22.00	Unit cost multiplier	16.922917	4.044271	0.241437		0.148604	8.511979	22.00

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	1,920	0	1,920	0	0	13,386	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,920	0	1,920	0	0	13,386	20.00
21.00	Total cost to be allocated	15,236	0	20,460	0	0	40,955	21.00
22.00	Unit cost multiplier	7.935417	0.000000	10.656250	0.000000	0.000000	3.059540	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1311
HHA CCN: 14-7612

Period: From 07/01/2022 To 06/30/2023

Worksheet H-2 Part II
Date/Time Prepared: 11/29/2023 10:22 am

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	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)			
		14.00	15.00	16.00	17.00			
1.00	Administrative and General	25,612	0	0	0			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19)	25,612	0	0	0			20.00
21.00	Total cost to be allocated	607	0	0	0			21.00
22.00	Unit cost multiplier	0.023700	0.000000	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-1311 HHA CCN: 14-7612 | Period: From 07/01/2022 To 06/30/2023 | Worksheet H-3 Part I Date/Time Prepared: 11/29/2023 10:22 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	646,749		646,749	1,687	383.37	1.00
2.00	Physical Therapy	3.00	116,031	0	116,031	733	158.30	2.00
3.00	Occupational Therapy	4.00	39,463	0	39,463	325	121.42	3.00
4.00	Speech Pathology	5.00	3,377	0	3,377	26	129.88	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	0		0	0	0.00	6.00
7.00	Total (sum of lines 1-6)		805,620	0	805,620	2,771		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	1,017			8.00
9.00	Physical Therapy		99914	0	532			9.00
10.00	Occupational Therapy		99914	0	264			10.00
11.00	Speech Pathology		99914	0	24			11.00
12.00	Medical Social Services		99914	0	0			12.00
13.00	Home Health Aide		99914	0	1			13.00
14.00	Total (sum of lines 8-13)			0	1,838			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	56,073	0	56,073	126,787	0.442261	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,017		0	389,887		1.00
2.00	Physical Therapy	0	532		0	84,216		2.00
3.00	Occupational Therapy	0	264		0	32,055		3.00
4.00	Speech Pathology	0	24		0	3,117		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	1		0	0		6.00
7.00	Total (sum of lines 1-6)	0	1,838		0	509,275		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1311 HHA CCN: 14-7612 | Period: From 07/01/2022 To 06/30/2023 | Worksheet H-3 Part I Date/Time Prepared: 11/29/2023 10:22 am

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

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	65,506	0	0	28,971	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	389,887						1.00
2.00	Physical Therapy	84,216						2.00
3.00	Occupational Therapy	32,055						3.00
4.00	Speech Pathology	3,117						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	0						6.00
7.00	Total (sum of lines 1-6)	509,275						7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-1311 | HHA CCN: 14-7612 | Period: From 07/01/2022 To 06/30/2023 | Worksheet H-3 Part II | Date/Time Prepared: 11/29/2023 10:22 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.397972	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.455493	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.611316	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.292220	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.356700	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1311 | HHA CCN: 14-7612 | Period: From 07/01/2022 To 06/30/2023 | Worksheet H-4 Part I-II | Date/Time Prepared: 11/29/2023 10:22 am

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		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	359,369	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	43,038	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	6,194	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	2,120	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	9,065	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	59	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	419,845	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	419,845	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	419,845	26.00
27.00	Allowable bad debts (from your records)		0	27.00
27.01	Adjusted reimbursable bad debts (see instructions)		0	27.01
28.00	Allowable bad debts for dual eligible (see instructions)		0	28.00
29.00	Total costs - current cost reporting period (see instructions)	0	419,845	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	419,845	31.00
31.01	Sequestration adjustment (see instructions)	0	8,377	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	1,896	31.02
31.75	Sequestration adjustment for non-claims based amounts (see instructions)	0	0	31.75
32.00	Interim payments (see instructions)	0	409,571	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)	0	1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 14-1311 | HHA CCN: 14-7612 | Period: From 07/01/2022 To 06/30/2023 | Worksheet H-5 | Date/Time Prepared: 11/29/2023 10:22 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		409,571	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		409,571	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		409,572	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1311 | Component CCN: 14-8500 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/29/2023 10:22 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	1,580,242	0	1,580,242	-68	1,580,174	1.00
2.00	Physician Assistant	322,460	0	322,460	-151	322,309	2.00
3.00	Nurse Practitioner	465,730	0	465,730	-137	465,593	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	250,881	0	250,881	-4,040	246,841	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,619,313	0	2,619,313	-4,396	2,614,917	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	239,328	239,328	0	239,328	15.00
16.00	Transportation (Health Care Staff)	0	38,044	38,044	0	38,044	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	277,372	277,372	0	277,372	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,619,313	277,372	2,896,685	-4,396	2,892,289	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	5,745	5,745	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	5,745	5,745	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	13,288	13,288	0	13,288	29.00
30.00	Administrative Costs	1,618,846	378,539	1,997,385	80,132	2,077,517	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,618,846	391,827	2,010,673	80,132	2,090,805	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,238,159	669,199	4,907,358	81,481	4,988,839	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1311 | Component CCN: 14-8500 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/29/2023 10:22 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,580,174		1.00
2.00	Physician Assistant	0	322,309		2.00
3.00	Nurse Practitioner	0	465,593		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	246,841		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,614,917		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	239,328		15.00
16.00	Transportation (Health Care Staff)	0	38,044		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	277,372		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,892,289		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	5,745		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	5,745		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	13,288		29.00
30.00	Administrative Costs	-509,148	1,568,369		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-509,148	1,581,657		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-509,148	4,479,691		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1311 | Component CCN: 14-8500 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-2 | Date/Time Prepared: 11/29/2023 10:22 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	2.97	6,555	4,200	12,474		1.00
2.00	Physician Assistant	2.42	5,431	2,100	5,082		2.00
3.00	Nurse Practitioner	4.48	10,060	2,100	9,408		3.00
4.00	Subtotal (sum of lines 1 through 3)	9.87	22,046		26,964	26,964	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	2.40	2,240			2,240	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)	12.27	24,286			29,204	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,892,289	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					5,745	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,898,034	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.998018	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,581,657	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,591,468	15.00
16.00	Total overhead (sum of lines 14 and 15)					5,173,125	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					5,173,125	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					5,162,872	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					8,055,161	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1311 Component CCN: 14-8500	Period: From 07/01/2022 To 06/30/2023	Worksheet M-3 Date/Time Prepared: 11/29/2023 10:22 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)		8,055,161	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		78,580	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		7,976,581	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		29,204	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)		29,204	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		273.13	7.00

		Calculation of Limit (1)		
		Rate Period 1 (07/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 06/30/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	285.81	296.67	8.00
9.00	Rate for Program covered visits (see instructions)	273.13	273.13	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	3,157	3,158	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	862,271	862,545	11.00
12.00	Program covered visits for mental health services (from contractor records)	57	58	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	15,568	15,842	13.00
14.00	Limit adjustment for mental health services (see instructions)	15,568	15,842	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	1,756,226	16.00
16.01	Total program charges (see instructions)(from contractor's records)		926,329	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		96,178	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		182,344	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,167,362	16.04
16.05	Total program cost (see instructions)	0	1,349,706	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		114,680	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		142,809	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,349,706	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		54,473	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,404,179	22.00
23.00	Allowable bad debts (see instructions)		72,064	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		46,842	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		61,750	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)		1,451,021	26.00
26.01	Sequestration adjustment (see instructions)		29,020	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		1,356,273	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)		65,728	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		25,222	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1311 | Component CCN: 14-8500 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-4 | Date/Time Prepared: 11/29/2023 10:22 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)	2,614,917	2,614,917	2,614,917	2,614,917	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000451	0.002148	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,179	5,617	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	10,842	10,578	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	12,021	16,195	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,892,289	2,892,289	2,892,289	2,892,289	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	5,162,872	5,162,872	5,162,872	5,162,872	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.004156	0.005599	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	21,457	28,907	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	33,478	45,102	0	0	10.00
11.00	Total number of injections/infusions (from your records)	69	329	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	485.19	137.09	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	60	185	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)	29,111	25,362	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)		78,580	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)		54,473	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1311 Component CCN: 14-8500	Period: From 07/01/2022 To 06/30/2023	Worksheet M-5 Date/Time Prepared: 11/29/2023 10:22 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		1,356,273	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,356,273	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		65,728	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,422,001	7.00

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