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: 14-1338	Period: From 07/01/2022 To 06/30/2023	Worksheet S Parts I-III Date/Time Prepared: 11/28/2023 3:50 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/28/2023 Time: 3:50 pm
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 MEMORIAL HOSPITAL (14-1338) 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				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				2
3	Signatory Title				3
4	Date				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	-115,551	206,900	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	-3,382	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		110,580		0	10.00
10.01	RURAL HEALTH CLINIC II	0		0		0	10.01
200.00	TOTAL	0	-118,933	317,480	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: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2023 3:50 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1900 STATE STREET	PO Box:			1.00
2.00	City: CHESTER	State: IL	Zip Code: 62233	County: RANDOLPH	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	MEMORIAL HOSPITAL	141338	99914	1	09/01/2004	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	MEMORIAL HOSPITAL-SWING BEDS	14Z338	99914		09/01/2004	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	CHESTER CLINIC	148543	99914		06/01/2015	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	STEELEVILLE FAMILY PRACTICE	148542	99914		06/01/2015	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2022	06/30/2023	20.00
21.00	Type of Control (see instructions)	8		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.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2023 3:50 pm

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

		Urban/Rural 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: 14-1338	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/28/2023 3:50 pm

		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: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2023 3:50 pm

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

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

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

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

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		1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)		
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?	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	Y	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	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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.	Y	Y	Y	N	109.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2023 3:50 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	385,118	25,336	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)	N		140.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2023 3:50 pm

					1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
					1.00	
	Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

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

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.00	169.00
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/28/2023 3:50 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/13/2023	Y	11/13/2023	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: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/28/2023 3:50 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	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.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	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.	PATRICIA	RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	FORVIS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314.231.5544	PATTY.RACHELL@FORVIS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1338	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part II Date/Time Prepared: 11/28/2023 3:50 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 11/28/2023 3:50 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	20,756.09	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	20,756.09	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	20,756.09	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						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2023 3:50 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	401	1	880			1.00
2.00	HMO and other (see instructions)	267	55				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	439	0	626			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	91			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	840	1	1,597			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)	840	1	1,597	0.00	185.34	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						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	4,749	154	18,974	0.00	39.14	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	224.48	27.00
28.00	Observation Bed Days		7	189			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: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2023 3:50 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	110	1	223	1.00
2.00	HMO and other (see instructions)			60	10		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	110	1	223	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1338 | Component CCN: 14-8543 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 11/28/2023 3:50 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			2319 OLD PLANK		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CHESTER		IL	62223	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	07:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			Y	2	13.00
			Provider name		CCN	
			1.00		2.00	
14.00	RHC/FQHC name, CCN		CHESTER CLINIC		148543	14.00
14.01			STEELEVILLE FAMILY PRACTICE CLINIC		148542	14.01

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	07:00	17:00	07:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1338 Component CCN: 14-8543	Period: From 07/01/2022 To 06/30/2023	Worksheet S-8 Date/Time Prepared: 11/28/2023 3:50 pm
		RHC I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-10 | Date/Time Prepared: 11/28/2023 3:50 pm

		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)	0.544854	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,283,115	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,123,863	5.00
6.00	Medicaid charges	6,953,050	6.00
7.00	Medicaid cost (line 1 times line 6)	3,788,397	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)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (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)	0	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)	19,365	76,056	95,421	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	10,551	76,056	86,607	21.00
22.00	Payments received from patients for amounts previously written off as charity care	60	5,528	5,588	22.00
23.00	Cost of charity care (line 21 minus line 22)	10,491	70,528	81,019	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)	639,233	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	136,482	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	209,971	27.01
28.00	Non-Medicare bad debt expense (see instructions)	429,262	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	307,374	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	388,393	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	388,393	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,695,702	1,695,702	-705,295	990,407	1.00
1.01	00101	CAP REL COSTS-B&F CHESTER CLINIC		0	0	23,116	23,116	1.01
1.02	00102	CAP REL COSTS-B&F STEELEVILLE		0	0	8,463	8,463	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	973,793	973,793	2.00
2.01	00201	CAP REL COSTS-MME CHESTER CLINIC		0	0	26,043	26,043	2.01
2.02	00202	CAP REL COSTS-MME STEELEVILLE		0	0	6,654	6,654	2.02
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	222,278	3,806,162	4,028,440	929,375	4,957,815	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,630,534	1,656,982	3,287,516	415,028	3,702,544	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	511,497	606,815	1,118,312	0	1,118,312	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	59,022	50,236	109,258	0	109,258	8.00
9.00	00900	HOUSEKEEPING	411,274	108,026	519,300	0	519,300	9.00
10.00	01000	DIETARY	418,606	250,243	668,849	-510,072	158,777	10.00
11.00	01100	CAFETERIA	0	0	0	510,072	510,072	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	325,633	60,346	385,979	0	385,979	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	131,234	703,289	834,523	-679,841	154,682	14.00
15.00	01500	PHARMACY	335,772	449,231	785,003	-337,439	447,564	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	467,368	74,571	541,939	0	541,939	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,036,239	262,106	2,298,345	431,632	2,729,977	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	756,396	274,502	1,030,898	-66,044	964,854	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	698,773	596,240	1,295,013	-62,583	1,232,430	54.00
60.00	06000	LABORATORY	828,007	1,192,746	2,020,753	-12,997	2,007,756	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	26,582	72,234	98,816	0	98,816	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	57,453	57,453	64.00
65.00	06500	RESPIRATORY THERAPY	273,116	99,609	372,725	-2,553	370,172	65.00
66.00	06600	PHYSICAL THERAPY	208,890	240,222	449,112	0	449,112	66.00
67.00	06700	OCCUPATIONAL THERAPY	59,615	40,394	100,009	0	100,009	67.00
68.00	06800	SPEECH PATHOLOGY	31,680	22,231	53,911	0	53,911	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	498,669	498,669	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	181,172	181,172	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	337,439	337,439	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	237,935	2,238,899	2,476,834	-38,475	2,438,359	76.01
76.02	03020	WOUND CARE	1,388	119,324	120,712	1,648	122,360	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,338,883	2,653,192	5,992,075	-1,982,170	4,009,905	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	331,307	479,801	811,108	0	811,108	90.00
91.00	09100	EMERGENCY	842,485	1,888,193	2,730,678	-3,088	2,727,590	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,184,514	19,641,296	33,825,810	0	33,825,810	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	4,319	330	4,649	0	4,649	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	168,757	417,397	586,154	0	586,154	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	14,357,590	20,059,023	34,416,613	0	34,416,613	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	990,407		1.00
1.01	00101	CAP REL COSTS-B&F CHESTER CLINIC	0	23,116		1.01
1.02	00102	CAP REL COSTS-B&F STEELEVILLE	0	8,463		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	973,793		2.00
2.01	00201	CAP REL COSTS-MME CHESTER CLINIC	0	26,043		2.01
2.02	00202	CAP REL COSTS-MME STEELEVILLE	0	6,654		2.02
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-180,492	4,777,323		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-234,767	3,467,777		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	-1,975	1,116,337		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	109,258		8.00
9.00	00900	HOUSEKEEPING	0	519,300		9.00
10.00	01000	DIETARY	0	158,777		10.00
11.00	01100	CAFETERIA	-51,351	458,721		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	385,979		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-280	154,402		14.00
15.00	01500	PHARMACY	-64,657	382,907		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-9,368	532,571		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
20.00	02000	NURSING PROGRAM	0	0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-447,478	2,282,499		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	964,854		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,232,430		54.00
60.00	06000	LABORATORY	0	2,007,756		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	98,816		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400	INTRAVENOUS THERAPY	0	57,453		64.00
65.00	06500	RESPIRATORY THERAPY	-50,264	319,908		65.00
66.00	06600	PHYSICAL THERAPY	-55,799	393,313		66.00
67.00	06700	OCCUPATIONAL THERAPY	-37,843	62,166		67.00
68.00	06800	SPEECH PATHOLOGY	-18,233	35,678		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	498,669		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	181,172		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	337,439		73.00
76.00	03950	CARDIAC REHAB	0	0		76.00
76.01	03951	CHEMOTHERAPY	-158,705	2,279,654		76.01
76.02	03020	WOUND CARE	-26,863	95,497		76.02
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-965,967	3,043,938		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
90.00	09000	CLINIC	-432,080	379,028		90.00
91.00	09100	EMERGENCY	-1,376,647	1,350,943		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,112,769	29,713,041		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	4,649		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		192.00
193.01	19301	AFTER CARE PROGRAM	0	0		193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0		194.00
194.01	07951	RETAIL PHARMACY	0	586,154		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,112,769	30,303,844		200.00

RECLASSIFICATIONS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/28/2023 3:50 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS DRUG COST				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	337,439	1.00
	0		0	337,439	
	B - RECLASS DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	827,486	1.00
2.00	CAP REL COSTS-B&F CHESTER CLINIC	1.01	0	23,116	2.00
3.00	CAP REL COSTS-B&F STEELEVILLE	1.02	0	8,463	3.00
4.00	CAP REL COSTS-MME CHESTER CLINIC	2.01	0	26,043	4.00
5.00	CAP REL COSTS-MME STEELEVILLE	2.02	0	6,654	5.00
	0		0	891,762	
	C - RECLASS MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	498,669	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	181,172	2.00
	0		0	679,841	
	F - CAFETERIA				
1.00	CAFETERIA	11.00	319,234	190,838	1.00
	0		319,234	190,838	
	H - LEASE/RENTAL				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	146,307	1.00
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
	0		0	146,307	
	I - RHC ADMINISTRATION				
1.00	ADMINISTRATIVE & GENERAL	5.00	350,373	189,020	1.00
	0		350,373	189,020	
	L - RECLASS PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	122,191	1.00
	0		0	122,191	
	M - TO RECLASS IV THERAPY EXPENSE				
1.00	INTRAVENOUS THERAPY	64.00	53,460	3,993	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
	0		53,460	3,993	
	N - TO RECLASS RHC HOSPITALIST EXPENSE				
1.00	ADULTS & PEDIATRICS	30.00	421,672	25,806	1.00
	0		421,672	25,806	
	O - TO RECLASS DIRECT ASSGND RHC BENEFIT				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	929,375	1.00
	TOTALS		0	929,375	
	P - TO RECLASS WOUND CLINIC EXPENSE				
1.00	WOUND CARE	76.02	0	1,648	1.00
	TOTALS		0	1,648	
500.00	Grand Total: Increases		1,144,739	3,518,220	500.00

RECLASSIFICATIONS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/28/2023 3:50 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS DRUG COST						
1.00	PHARMACY	15.00	0	337,439	0		1.00
	0		0	337,439			
	B - RECLASS DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	827,486	9		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	64,276	9		2.00
3.00		0.00	0	0	9		3.00
4.00		0.00	0	0	9		4.00
5.00		0.00	0	0	9		5.00
	0		0	891,762			
	C - RECLASS MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	679,841	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	679,841			
	F - CAFETERIA						
1.00	DIETARY	10.00	319,234	190,838	0		1.00
	0		319,234	190,838			
	H - LEASE/RENTAL						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,174	10		1.00
3.00	OPERATING ROOM	50.00	0	66,000	0		3.00
4.00	LABORATORY	60.00	0	12,997	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	2,553	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	62,583	0		6.00
	0		0	146,307			
	I - RHC ADMINISTRATION						
1.00	RURAL HEALTH CLINIC	88.00	350,373	189,020	0		1.00
	0		350,373	189,020			
	L - RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	122,191	12		1.00
	0		0	122,191			
	M - TO RECLASS IV THERAPY EXPENSE						
1.00	EMERGENCY	91.00	2,901	187	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	14,681	1,165	0		2.00
3.00	CHEMOTHERAPY	76.01	35,837	2,638	0		3.00
4.00	OPERATING ROOM	50.00	41	3	0		4.00
	0		53,460	3,993			
	N - TO RECLASS RHC HOSPITALIST EXPENSE						
1.00	RURAL HEALTH CLINIC	88.00	421,672	25,806	0		1.00
	0		421,672	25,806			
	O - TO RECLASS DIRECT ASSGND RHC BENEFIT						
1.00	RURAL HEALTH CLINIC	88.00	0	929,375	0		1.00
	TOTALS		0	929,375			
	P - TO RECLASS WOUND CLINIC EXPENSE						
1.00	RURAL HEALTH CLINIC	88.00	0	1,648	0		1.00
	TOTALS		0	1,648			
500.00	Grand Total: Decreases		1,144,739	3,518,220			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 11/28/2023 3:50 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	232,983	0	0	0	0	1.00
2.00	Land Improvements	724,211	0	0	0	0	2.00
3.00	Buildings and Fixtures	23,033,040	2,545,007	0	2,545,007	1,151,974	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,139,610	88,805	0	88,805	0	5.00
6.00	Movable Equipment	13,002,773	409,886	0	409,886	584,262	6.00
7.00	HIT designated Assets	1,560,155	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	39,692,772	3,043,698	0	3,043,698	1,736,236	8.00
9.00	Reconciling Items	228,387	2,534,744	0	2,534,744	2,303,143	9.00
10.00	Total (line 8 minus line 9)	39,464,385	508,954	0	508,954	-566,907	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	232,983	0	1.00
2.00	Land Improvements	724,211	0	2.00
3.00	Buildings and Fixtures	24,426,073	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	1,228,415	0	5.00
6.00	Movable Equipment	12,828,397	0	6.00
7.00	HIT designated Assets	1,560,155	0	7.00
8.00	Subtotal (sum of lines 1-7)	41,000,234	0	8.00
9.00	Reconciling Items	459,988	0	9.00
10.00	Total (line 8 minus line 9)	40,540,246	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 11/28/2023 3:50 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,695,702	0	0	0	0	1.00
1.01	CAP REL COSTS-B&F CHESTER CLINIC	0	0	0	0	0	1.01
1.02	CAP REL COSTS-B&F STEELEVILLE	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
2.01	CAP REL COSTS-MME CHESTER CLINIC	0	0	0	0	0	2.01
2.02	CAP REL COSTS-MME STEELEVILLE	0	0	0	0	0	2.02
3.00	Total (sum of lines 1-2)	1,695,702	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	1,695,702	1.00
1.01	CAP REL COSTS-B&F CHESTER CLINIC	0	0	1.01
1.02	CAP REL COSTS-B&F STEELEVILLE	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
2.01	CAP REL COSTS-MME CHESTER CLINIC	0	0	2.01
2.02	CAP REL COSTS-MME STEELEVILLE	0	0	2.02
3.00	Total (sum of lines 1-2)	0	1,695,702	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part III | Date/Time Prepared: 11/28/2023 3:50 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	26,611,682	0	26,611,682	0.649062	0	1.00
1.01	CAP REL COSTS-B&F CHESTER CLINIC	0	0	0	0.000000	0	1.01
1.02	CAP REL COSTS-B&F STEELEVILLE	0	0	0	0.000000	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	14,388,551	0	14,388,551	0.350938	0	2.00
2.01	CAP REL COSTS-MME CHESTER CLINIC	0	0	0	0.000000	0	2.01
2.02	CAP REL COSTS-MME STEELEVILLE	0	0	0	0.000000	0	2.02
3.00	Total (sum of lines 1-2)	41,000,233	0	41,000,233	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	868,216	0	1.00
1.01	CAP REL COSTS-B&F CHESTER CLINIC	0	0	0	23,116	0	1.01
1.02	CAP REL COSTS-B&F STEELEVILLE	0	0	0	8,463	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	827,486	146,307	2.00
2.01	CAP REL COSTS-MME CHESTER CLINIC	0	0	0	26,043	0	2.01
2.02	CAP REL COSTS-MME STEELEVILLE	0	0	0	6,654	0	2.02
3.00	Total (sum of lines 1-2)	0	0	0	1,759,978	146,307	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	122,191	0	0	990,407	1.00
1.01	CAP REL COSTS-B&F CHESTER CLINIC	0	0	0	0	23,116	1.01
1.02	CAP REL COSTS-B&F STEELEVILLE	0	0	0	0	8,463	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	973,793	2.00
2.01	CAP REL COSTS-MME CHESTER CLINIC	0	0	0	0	26,043	2.01
2.02	CAP REL COSTS-MME STEELEVILLE	0	0	0	0	6,654	2.02
3.00	Total (sum of lines 1-2)	0	122,191	0	0	2,028,476	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/28/2023 3:50 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-B&F CHESTER CLINIC (chapter 2)		0	CAP REL COSTS-B&F CHESTER CLINIC	1.01	0	1.01
1.02	Investment income - CAP REL COSTS-B&F STEELEVILLE (chapter 2)		0	CAP REL COSTS-B&F STEELEVILLE	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - CAP REL COSTS-MME CHESTER CLINIC (chapter 2)		0	CAP REL COSTS-MME CHESTER CLINIC	2.01	0	2.01
2.02	Investment income - CAP REL COSTS-MME STEELEVILLE (chapter 2)		0	CAP REL COSTS-MME STEELEVILLE	2.02	0	2.02
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-64,657	PHARMACY	15.00	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	0	ADULTS & PEDIATRICS	30.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,446,987			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-1,975	OPERATION OF PLANT	7.00	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	-49,876	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	B	0	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-9,368	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/28/2023 3:50 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-B&F CHESTER CLINIC		0	CAP REL COSTS-B&F CHESTER CLINIC	1.01	0	26.01
26.02	Depreciation - CAP REL COSTS-B&F STEELEVILLE		0	CAP REL COSTS-B&F STEELEVILLE	1.02	0	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - CAP REL COSTS-MME CHESTER CLINIC		0	CAP REL COSTS-MME CHESTER CLINIC	2.01	0	27.01
27.02	Depreciation - CAP REL COSTS-MME STEELEVILLE		0	CAP REL COSTS-MME STEELEVILLE	2.02	0	27.02
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	NON ALLOW LOBBYING DUES	A	-10,927	ADMINISTRATIVE & GENERAL	5.00	0	33.00
35.00	MKT SALARY	A	-47,671	ADMINISTRATIVE & GENERAL	5.00	0	35.00
35.01	MKT OTHER	A	-51,042	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.02	CRNA AND SURGEON BILLING SALARY	A	-98,484	ADMINISTRATIVE & GENERAL	5.00	0	35.02
40.00	RHC CRNA EXPENSE	A	-639,398	RURAL HEALTH CLINIC	88.00	0	40.00
41.00	RHC SURGEON	A	-325,849	RURAL HEALTH CLINIC	88.00	0	41.00
42.00	RHC PHYSICIAN FEES	A	-720	RURAL HEALTH CLINIC	88.00	0	42.00
44.01	NON ALLOW DR MEALS	A	0	DIETARY	10.00	0	44.01
45.00	NON OP REV	B	-4,860	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	NON OP REV	B	-280	CENTRAL SERVICES & SUPPLY	14.00	0	45.01
45.02	RHC LAB CHARGES	A	0	RURAL HEALTH CLINIC	88.00	0	45.02
45.03	NON OP REV	B	-1,475	CAFETERIA	11.00	0	45.03
45.04	AUDIOLOGY	A	-45,050	CLINIC	90.00	0	45.04
45.05	NON OP REV	B	-55,799	PHYSICAL THERAPY	66.00	0	45.05
45.06	NON OP REV	B	-37,843	OCCUPATIONAL THERAPY	67.00	0	45.06
45.07	NON OP REV	B	-18,233	SPEECH PATHOLOGY	68.00	0	45.07
45.08	CRNA AND SURGEON BILLING OTHER	A	-21,783	ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09	CRNA AND SURGEON BILLING BENEFITS	A	-31,305	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.09
45.10	MKT BENEFITS	A	-15,153	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.10
45.11	RHC NON-PHY BENEFITS - A&P	A	-134,034	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,112,769				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 11/28/2023 3:50 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	447,478	447,478	0	0	0	1.00
2.00	76.02	AGGREGATE-WOUND CARE	26,863	26,863	0	0	0	2.00
3.00	90.00	AGGREGATE-CLINIC	387,030	387,030	0	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	1,745,885	1,376,647	369,238	0	0	4.00
5.00	76.01	AGGREGATE-CHEMOTHERAPY	158,705	158,705	0	0	0	5.00
6.00	60.00	AGGREGATE-LABORATORY	20,400	0	20,400	0	0	6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	50,264	50,264	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			2,836,625	2,446,987	389,638		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	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	76.02	AGGREGATE-WOUND CARE	0	0	0	0	0	2.00
3.00	90.00	AGGREGATE-CLINIC	0	0	0	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	4.00
5.00	76.01	AGGREGATE-CHEMOTHERAPY	0	0	0	0	0	5.00
6.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	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	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	447,478		1.00
2.00	76.02	AGGREGATE-WOUND CARE	0	0	0	26,863		2.00
3.00	90.00	AGGREGATE-CLINIC	0	0	0	387,030		3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	1,376,647		4.00
5.00	76.01	AGGREGATE-CHEMOTHERAPY	0	0	0	158,705		5.00
6.00	60.00	AGGREGATE-LABORATORY	0	0	0	0		6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	50,264		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,446,987		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/28/2023 3:50 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					27	1.00
2.00	Line 1 multiplied by 15 hours per week					405	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.78	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	284.60	1,621.20	1,321.40	1,079.40	0.00	9.00
10.00	AHSEA (see instructions)	118.94	95.15	71.36	33.30	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	47.58	47.58	35.68			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					33,850	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					154,257	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					94,295	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					282,402	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					35,944	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					318,346	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					318,346	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/28/2023 3:50 pm

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	95.15	71.36	33.30	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	318,346		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	318,346		63.00
64.00	Total cost of outside supplier services (from your records)	215,417		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

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		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		27	1.00
2.00	Line 1 multiplied by 15 hours per week		405	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.78	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	2.10	618.10	4.30	0.00	0.00	9.00
10.00	AHSEA (see instructions)	112.74	90.20	67.65	31.57	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	45.10	45.10	33.83			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	237	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	55,753	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	291	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	56,281	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	56,281	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	56,281	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	90.20	67.65	31.57	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		56,281	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		56,281	63.00
64.00	Total cost of outside supplier services (from your records)		36,102	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		0	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		0	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1338	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/28/2023 3:50 pm

Speech Pathology — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					27	1.00
2.00	Line 1 multiplied by 15 hours per week					405	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.78	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	0.00	484.10	0.00	0.00	9.00
10.00	AHSEA (see instructions)	108.34	86.67	65.00	30.34	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	43.34	43.34	32.50			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					0	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					31,467	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					31,467	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					31,467	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					31,467	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/28/2023 3:50 pm

Speech Pathology — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	86.67	65.00	30.34	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	31,467		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	31,467		63.00
64.00	Total cost of outside supplier services (from your records)	18,723		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	B&F CHESTER CLINIC	B&F STEELEVILLE	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	990,407	990,407				1.00
1.01	00101	CAP REL COSTS-B&F CHESTER CLINIC	23,116	0	23,116			1.01
1.02	00102	CAP REL COSTS-B&F STEELEVILLE	8,463	0	0	8,463		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	973,793				973,793	2.00
2.01	00201	CAP REL COSTS-MME CHESTER CLINIC	26,043				0	2.01
2.02	00202	CAP REL COSTS-MME STEELEVILLE	6,654				0	2.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,777,323	9,813	0	0	9,649	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,467,777	181,194	0	0	178,153	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,116,337	136,767	0	0	134,473	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	109,258	7,915	0	0	7,782	8.00
9.00	00900	HOUSEKEEPING	519,300	15,997	0	0	15,729	9.00
10.00	01000	DIETARY	158,777	5,795	0	0	5,698	10.00
11.00	01100	CAFETERIA	458,721	27,154	0	0	26,698	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	385,979	20,249	0	0	19,909	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	154,402	13,321	0	0	13,098	14.00
15.00	01500	PHARMACY	382,907	14,221	0	0	13,982	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	532,571	14,698	0	0	14,451	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,282,499	105,328	0	0	103,562	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	964,854	93,417	0	0	91,850	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,232,430	57,604	0	0	56,638	54.00
60.00	06000	LABORATORY	2,007,756	26,055	0	0	25,618	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	98,816	1,599	0	0	1,572	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	57,453	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	319,908	16,707	0	0	16,427	65.00
66.00	06600	PHYSICAL THERAPY	393,313	79,363	0	0	78,031	66.00
67.00	06700	OCCUPATIONAL THERAPY	62,166	12,023	0	0	11,821	67.00
68.00	06800	SPEECH PATHOLOGY	35,678	6,328	0	0	6,222	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	498,669	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	181,172	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	337,439	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	2,279,654	24,045	0	0	23,642	76.01
76.02	03020	WOUND CARE	95,497	3,863	0	0	3,798	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,043,938	0	23,116	8,463	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	379,028	38,821	0	0	38,170	90.00
91.00	09100	EMERGENCY	1,350,943	48,568	0	0	47,753	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,713,041	960,845	23,116	8,463	944,726	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	4,649	10,468	0	0	10,293	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	7,893	0	0	7,761	192.00
193.01	19301	AFTER CARE PROGRAM	0	6,761	0	0	6,647	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	586,154	4,440	0	0	4,366	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	30,303,844	990,407	23,116	8,463	973,793	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			MME CHESTER CLINIC	MME STEELEVILLE	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			2.01	2.02	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-B&F CHESTER CLINIC						1.01
1.02	00102	CAP REL COSTS-B&F STEELEVILLE						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MME CHESTER CLINIC	26,043					2.01
2.02	00202	CAP REL COSTS-MME STEELEVILLE	0	6,654				2.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	4,796,785			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	0	648,677	4,475,801	4,475,801	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	180,840	1,568,417	271,794	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	20,867	145,822	25,270	8.00
9.00	00900	HOUSEKEEPING	0	0	145,406	696,432	120,686	9.00
10.00	01000	DIETARY	0	0	35,133	205,403	35,595	10.00
11.00	01100	CAFETERIA	0	0	112,865	625,438	108,383	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	115,128	541,265	93,797	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	46,398	227,219	39,375	14.00
15.00	01500	PHARMACY	0	0	118,712	529,822	91,814	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	165,238	726,958	125,976	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	714,722	3,206,111	555,593	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	267,409	1,417,530	245,647	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	247,051	1,593,723	276,179	54.00
60.00	06000	LABORATORY	0	0	292,742	2,352,171	407,612	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	9,398	111,385	19,302	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	18,901	76,354	13,232	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	96,560	449,602	77,912	65.00
66.00	06600	PHYSICAL THERAPY	0	0	73,853	624,560	108,231	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	21,077	107,087	18,557	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	11,200	59,428	10,298	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	498,669	86,415	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	181,172	31,396	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	337,439	58,475	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	0	71,452	2,398,793	415,692	76.01
76.02	03020	WOUND CARE	0	0	491	103,649	17,962	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	26,043	6,654	907,505	4,015,719	695,902	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	117,134	573,153	99,323	90.00
91.00	09100	EMERGENCY	0	0	296,835	1,744,099	302,238	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,043	6,654	4,735,594	29,593,221	4,352,656	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	1,527	26,937	4,668	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	15,654	2,713	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	13,408	2,323	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	59,664	654,624	113,441	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	26,043	6,654	4,796,785	30,303,844	4,475,801	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-B&F CHESTER CLINIC						1.01
1.02	00102	CAP REL COSTS-B&F STEELEVILLE						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MME CHESTER CLINIC						2.01
2.02	00202	CAP REL COSTS-MME STEELEVILLE						2.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	1,840,211				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,981	193,073			8.00
9.00	00900	HOUSEKEEPING	0	44,425	0	861,543		9.00
10.00	01000	DIETARY	0	16,093	0	7,816	264,907	10.00
11.00	01100	CAFETERIA	0	75,409	0	36,626	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	56,233	0	27,313	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	36,995	0	17,969	0	14.00
15.00	01500	PHARMACY	0	39,493	0	19,182	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	40,818	0	19,826	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	292,510	193,073	142,072	264,907	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	259,430	0	126,006	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	159,974	0	77,700	0	54.00
60.00	06000	LABORATORY	0	72,357	0	35,144	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,439	0	2,156	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	46,398	0	22,536	0	65.00
66.00	06600	PHYSICAL THERAPY	0	220,400	0	107,049	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	33,388	0	16,217	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	17,573	0	8,535	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	66,777	0	32,434	0	76.01
76.02	03020	WOUND CARE	0	10,729	0	5,211	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT 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
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	107,811	0	52,364	0	90.00
91.00	09100	EMERGENCY	0	134,879	0	65,511	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,758,112	193,073	821,667	264,907	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	29,072	0	14,120	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	21,920	0	10,647	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	18,775	0	9,119	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	12,332	0	5,990	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,840,211	193,073	861,543	264,907	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-B&F CHESTER CLINIC						1.01
1.02	00102	CAP REL COSTS-B&F STEELEVILLE						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MME CHESTER CLINIC						2.01
2.02	00202	CAP REL COSTS-MME STEELEVILLE						2.02
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	845,856					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	35,470	0	754,078			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,295	0	0	335,853		14.00
15.00	01500	PHARMACY	36,574	0	0	0	716,885	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	50,908	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	220,196	0	393,593	9,370	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	82,386	0	147,262	14,654	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	76,114	0	0	3,860	0	54.00
60.00	06000	LABORATORY	90,191	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,895	0	0	216	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	5,823	0	10,409	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	29,749	0	0	2,678	0	65.00
66.00	06600	PHYSICAL THERAPY	22,753	0	0	175	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,494	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,451	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	213,337	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	77,491	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	101,690	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	22,014	0	39,348	4,856	615,195	76.01
76.02	03020	WOUND CARE	151	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT 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
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	36,088	0	0	1,754	0	90.00
91.00	09100	EMERGENCY	91,452	0	163,466	7,462	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	827,004	0	754,078	335,853	716,885	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	470	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	18,382	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	845,856	0	754,078	335,853	716,885	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	
			16.00	17.00	19.00	20.00	21.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-B&F CHESTER CLINIC						1.01
1.02	00102	CAP REL COSTS-B&F STEELEVILLE						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MME CHESTER CLINIC						2.01
2.02	00202	CAP REL COSTS-MME STEELEVILLE						2.02
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	964,486					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING PROGRAM	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,147	0	0	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	57,089	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	242,498	0	0	0	0	54.00
60.00	06000	LABORATORY	225,116	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,272	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	5,892	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	35,556	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	40,482	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,132	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,226	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	90,988	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,721	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	38,196	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	83,714	0	0	0	0	76.01
76.02	03020	WOUND CARE	6,542	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT 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
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	10,497	0	0	0	0	90.00
91.00	09100	EMERGENCY	69,418	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	964,486	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	0	0	0	194.01
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)	964,486	0	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			22.00	23.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-B&F CHESTER CLINIC						1.01
1.02	00102	CAP REL COSTS-B&F STEELEVILLE						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MME CHESTER CLINIC						2.01
2.02	00202	CAP REL COSTS-MME STEELEVILLE						2.02
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	5,315,572	0	5,315,572	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	2,350,004	0	2,350,004	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,430,048	0	2,430,048	54.00
60.00	06000	LABORATORY	0	0	3,182,591	0	3,182,591	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	144,665	0	144,665	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	111,710	0	111,710	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	664,431	0	664,431	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,123,650	0	1,123,650	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	187,875	0	187,875	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	102,511	0	102,511	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	889,409	0	889,409	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	296,780	0	296,780	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	535,800	0	535,800	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	0	3,678,823	0	3,678,823	76.01
76.02	03020	WOUND CARE	0	0	144,244	0	144,244	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	4,711,621	0	4,711,621	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	880,990	0	880,990	90.00
91.00	09100	EMERGENCY	0	0	2,578,525	0	2,578,525	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	29,329,249	0	29,329,249	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	75,267	0	75,267	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	50,934	0	50,934	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	43,625	0	43,625	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	804,769	0	804,769	194.01
200.00		Cross Foot Adjustments	0	0	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)	0	0	30,303,844	0	30,303,844	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	B&F CHESTER CLINIC	B&F STEELEVILLE	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-B&F CHESTER CLINIC						1.01
1.02	00102	CAP REL COSTS-B&F STEELEVILLE						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MME CHESTER CLINIC						2.01
2.02	00202	CAP REL COSTS-MME STEELEVILLE						2.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,813	0	0	9,649	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	181,194	0	0	178,153	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	136,767	0	0	134,473	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,915	0	0	7,782	8.00
9.00	00900	HOUSEKEEPING	0	15,997	0	0	15,729	9.00
10.00	01000	DIETARY	0	5,795	0	0	5,698	10.00
11.00	01100	CAFETERIA	0	27,154	0	0	26,698	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	20,249	0	0	19,909	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	13,321	0	0	13,098	14.00
15.00	01500	PHARMACY	0	14,221	0	0	13,982	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,698	0	0	14,451	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	105,328	0	0	103,562	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	93,417	0	0	91,850	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	57,604	0	0	56,638	54.00
60.00	06000	LABORATORY	0	26,055	0	0	25,618	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,599	0	0	1,572	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	16,707	0	0	16,427	65.00
66.00	06600	PHYSICAL THERAPY	0	79,363	0	0	78,031	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,023	0	0	11,821	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,328	0	0	6,222	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	24,045	0	0	23,642	76.01
76.02	03020	WOUND CARE	0	3,863	0	0	3,798	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	23,116	8,463	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	38,821	0	0	38,170	90.00
91.00	09100	EMERGENCY	0	48,568	0	0	47,753	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	960,845	23,116	8,463	944,726	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	10,468	0	0	10,293	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	7,893	0	0	7,761	192.00
193.01	19301	AFTER CARE PROGRAM	0	6,761	0	0	6,647	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	4,440	0	0	4,366	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	990,407	23,116	8,463	973,793	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			MME CHESTER CLINIC	MME STEELEVILLE				
			2.01	2.02	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-B&F CHESTER CLINIC						1.01
1.02	00102	CAP REL COSTS-B&F STEELEVILLE						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MME CHESTER CLINIC						2.01
2.02	00202	CAP REL COSTS-MME STEELEVILLE						2.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	19,462	19,462		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	0	359,347	2,631	361,978	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	271,240	733	21,981	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	15,697	85	2,044	8.00
9.00	00900	HOUSEKEEPING	0	0	31,726	590	9,760	9.00
10.00	01000	DIETARY	0	0	11,493	142	2,879	10.00
11.00	01100	CAFETERIA	0	0	53,852	458	8,766	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	40,158	467	7,586	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	26,419	188	3,184	14.00
15.00	01500	PHARMACY	0	0	28,203	481	7,425	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	29,149	670	10,188	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	208,890	2,899	44,934	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	185,267	1,085	19,867	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	114,242	1,002	22,336	54.00
60.00	06000	LABORATORY	0	0	51,673	1,187	32,966	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	3,171	38	1,561	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	77	1,070	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	33,134	392	6,301	65.00
66.00	06600	PHYSICAL THERAPY	0	0	157,394	300	8,753	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	23,844	85	1,501	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	12,550	45	833	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	6,989	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,539	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,729	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	0	47,687	290	33,619	76.01
76.02	03020	WOUND CARE	0	0	7,661	2	1,453	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	26,043	6,654	64,276	3,688	56,277	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	76,991	475	8,033	90.00
91.00	09100	EMERGENCY	0	0	96,321	1,204	24,444	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,043	6,654	1,969,847	19,214	352,018	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	20,761	6	378	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	15,654	0	219	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	13,408	0	188	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	8,806	242	9,175	194.01
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	26,043	6,654	2,028,476	19,462	361,978	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-B&F CHESTER CLINIC						1.01
1.02	00102	CAP REL COSTS-B&F STEELEVILLE						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MME CHESTER CLINIC						2.01
2.02	00202	CAP REL COSTS-MME STEELEVILLE						2.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	293,954				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,511	21,337			8.00
9.00	00900	HOUSEKEEPING	0	7,096	0	49,172		9.00
10.00	01000	DIETARY	0	2,571	0	446	17,531	10.00
11.00	01100	CAFETERIA	0	12,046	0	2,090	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	8,983	0	1,559	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,910	0	1,026	0	14.00
15.00	01500	PHARMACY	0	6,309	0	1,095	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,520	0	1,132	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	46,725	21,337	8,107	17,531	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	41,441	0	7,192	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,554	0	4,435	0	54.00
60.00	06000	LABORATORY	0	11,558	0	2,006	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	709	0	123	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	7,412	0	1,286	0	65.00
66.00	06600	PHYSICAL THERAPY	0	35,207	0	6,110	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,333	0	926	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,807	0	487	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	10,667	0	1,851	0	76.01
76.02	03020	WOUND CARE	0	1,714	0	297	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT 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
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	17,222	0	2,989	0	90.00
91.00	09100	EMERGENCY	0	21,545	0	3,739	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	280,840	21,337	46,896	17,531	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	4,644	0	806	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	3,501	0	608	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	2,999	0	520	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	1,970	0	342	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	293,954	21,337	49,172	17,531	202.00

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		Cost Center Description	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-B&F CHESTER CLINIC						1.01
1.02	00102	CAP REL COSTS-B&F STEELEVILLE						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MME CHESTER CLINIC						2.01
2.02	00202	CAP REL COSTS-MME STEELEVILLE						2.02
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	77,212					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	3,238	0	61,991			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,305	0	0	38,032		14.00
15.00	01500	PHARMACY	3,339	0	0	0	46,852	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,647	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,099	0	32,356	1,061	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,520	0	12,106	1,659	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,948	0	0	437	0	54.00
60.00	06000	LABORATORY	8,233	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	264	0	0	24	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	532	0	856	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,716	0	0	303	0	65.00
66.00	06600	PHYSICAL THERAPY	2,077	0	0	20	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	593	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	315	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	24,159	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,775	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	6,646	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	2,009	0	3,235	550	40,206	76.01
76.02	03020	WOUND CARE	14	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT 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
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	3,294	0	0	199	0	90.00
91.00	09100	EMERGENCY	8,348	0	13,438	845	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,491	0	61,991	38,032	46,852	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	43	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	1,678	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	77,212	0	61,991	38,032	46,852	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	
			16.00	17.00	19.00	20.00	21.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-B&F CHESTER CLINIC						1.01
1.02	00102	CAP REL COSTS-B&F STEELEVILLE						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MME CHESTER CLINIC						2.01
2.02	00202	CAP REL COSTS-MME STEELEVILLE						2.02
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	52,306					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING PROGRAM	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,068	0				30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,095	0				50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,162	0				54.00
60.00	06000	LABORATORY	12,205	0				60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	232	0				62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
64.00	06400	INTRAVENOUS THERAPY	319	0				64.00
65.00	06500	RESPIRATORY THERAPY	1,928	0				65.00
66.00	06600	PHYSICAL THERAPY	2,195	0				66.00
67.00	06700	OCCUPATIONAL THERAPY	332	0				67.00
68.00	06800	SPEECH PATHOLOGY	175	0				68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,933	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	364	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,071	0				73.00
76.00	03950	CARDIAC REHAB	0	0				76.00
76.01	03951	CHEMOTHERAPY	4,539	0				76.01
76.02	03020	WOUND CARE	355	0				76.02
76.97	07697	CARDIAC REHABILITATION	0	0				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0				76.98
76.99	07699	LITHOTRIPSY	0	0				76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0				77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0				88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0				88.01
90.00	09000	CLINIC	569	0				90.00
91.00	09100	EMERGENCY	3,764	0				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0				102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,306	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0				190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0				192.00
193.01	19301	AFTER CARE PROGRAM	0	0				193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0				194.00
194.01	07951	RETAIL PHARMACY	0	0				194.01
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)	52,306	0	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			22.00	23.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-B&F CHESTER CLINIC						1.01
1.02	00102	CAP REL COSTS-B&F STEELEVILLE						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MME CHESTER CLINIC						2.01
2.02	00202	CAP REL COSTS-MME STEELEVILLE						2.02
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS			406,007	0	406,007	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM			279,232	0	279,232	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			188,116	0	188,116	54.00
60.00	06000	LABORATORY			119,828	0	119,828	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL			6,122	0	6,122	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS			0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY			2,854	0	2,854	64.00
65.00	06500	RESPIRATORY THERAPY			53,472	0	53,472	65.00
66.00	06600	PHYSICAL THERAPY			212,056	0	212,056	66.00
67.00	06700	OCCUPATIONAL THERAPY			32,614	0	32,614	67.00
68.00	06800	SPEECH PATHOLOGY			17,212	0	17,212	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT			36,081	0	36,081	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			11,678	0	11,678	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			13,446	0	13,446	73.00
76.00	03950	CARDIAC REHAB			0	0	0	76.00
76.01	03951	CHEMOTHERAPY			144,653	0	144,653	76.01
76.02	03020	WOUND CARE			11,496	0	11,496	76.02
76.97	07697	CARDIAC REHABILITATION			0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY			0	0	0	76.98
76.99	07699	LITHOTRIPSY			0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION			0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC			124,241	0	124,241	88.00
88.01	08801	RURAL HEALTH CLINIC II			0	0	0	88.01
90.00	09000	CLINIC			109,772	0	109,772	90.00
91.00	09100	EMERGENCY			173,648	0	173,648	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM			0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	1,942,528	0	1,942,528	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN			26,638	0	26,638	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES			19,982	0	19,982	192.00
193.01	19301	AFTER CARE PROGRAM			17,115	0	17,115	193.01
194.00	07950	NON-ALLOWABLE COSTS			0	0	0	194.00
194.01	07951	RETAIL PHARMACY			22,213	0	22,213	194.01
200.00		Cross Foot Adjustments	0	0	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)	0	0	2,028,476	0	2,028,476	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQ FEET)	B&F CHESTER CLINIC (SQ FEET)	B&F STEELEVILLE (SQ FEET)	MVBLE EQUIP (SQ FEET)	MME CHESTER CLINIC (SQ FEET)	
			1.00	1.01	1.02	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	89,216					1.00
1.01	00101	CAP REL COSTS-B&F CHESTER CLINIC	0	7,106				1.01
1.02	00102	CAP REL COSTS-B&F STEELEVILLE	0	0	3,028			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				89,216		2.00
2.01	00201	CAP REL COSTS-MME CHESTER CLINIC				0	7,106	2.01
2.02	00202	CAP REL COSTS-MME STEELEVILLE				0	0	2.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	884	0	0	884	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,322	0	0	16,322	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	12,320	0	0	12,320	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	713	0	0	713	0	8.00
9.00	00900	HOUSEKEEPING	1,441	0	0	1,441	0	9.00
10.00	01000	DIETARY	522	0	0	522	0	10.00
11.00	01100	CAFETERIA	2,446	0	0	2,446	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,824	0	0	1,824	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,200	0	0	1,200	0	14.00
15.00	01500	PHARMACY	1,281	0	0	1,281	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,324	0	0	1,324	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,488	0	0	9,488	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,415	0	0	8,415	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,189	0	0	5,189	0	54.00
60.00	06000	LABORATORY	2,347	0	0	2,347	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	144	0	0	144	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,505	0	0	1,505	0	65.00
66.00	06600	PHYSICAL THERAPY	7,149	0	0	7,149	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,083	0	0	1,083	0	67.00
68.00	06800	SPEECH PATHOLOGY	570	0	0	570	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	2,166	0	0	2,166	0	76.01
76.02	03020	WOUND CARE	348	0	0	348	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,106	3,028	0	7,106	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	3,497	0	0	3,497	0	90.00
91.00	09100	EMERGENCY	4,375	0	0	4,375	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	86,553	7,106	3,028	86,553	7,106	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	943	0	0	943	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	711	0	0	711	0	192.00
193.01	19301	AFTER CARE PROGRAM	609	0	0	609	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	400	0	0	400	0	194.01
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)	990,407	23,116	8,463	973,793	26,043	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.101226	3.253026	2.794914	10.915004	3.664931	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQ FEET)	B&F CHESTER CLINIC (SQ FEET)	B&F STEELEVILLE (SQ FEET)	MVBLE EQUIP (SQ FEET)	MME CHESTER CLINIC (SQ FEET)	
			1.00	1.01	1.02	2.00	2.01	
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	CAPITAL RELATED COSTS MME STEELEVILLE (SQ FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (GROSS SALARIES)	
			2.02	4.00	5A	5.00	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-B&F CHESTER CLINIC						1.01
1.02	00102	CAP REL COSTS-B&F STEELEVILLE						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MME CHESTER CLINIC						2.01
2.02	00202	CAP REL COSTS-MME STEELEVILLE	3,028					2.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	13,567,485				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,834,752	-4,475,801	25,828,043		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	511,497	0	1,568,417	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	59,022	0	145,822	0	8.00
9.00	00900	HOUSEKEEPING	0	411,274	0	696,432	0	9.00
10.00	01000	DIETARY	0	99,372	0	205,403	0	10.00
11.00	01100	CAFETERIA	0	319,234	0	625,438	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	325,633	0	541,265	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	131,234	0	227,219	0	14.00
15.00	01500	PHARMACY	0	335,772	0	529,822	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	467,368	0	726,958	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,021,558	0	3,206,111	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	756,355	0	1,417,530	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	698,773	0	1,593,723	0	54.00
60.00	06000	LABORATORY	0	828,007	0	2,352,171	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	26,582	0	111,385	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	53,460	0	76,354	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	273,116	0	449,602	0	65.00
66.00	06600	PHYSICAL THERAPY	0	208,890	0	624,560	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	59,615	0	107,087	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	31,680	0	59,428	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	498,669	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	181,172	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	337,439	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	202,098	0	2,398,793	0	76.01
76.02	03020	WOUND CARE	0	1,388	0	103,649	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,028	2,566,838	0	4,015,719	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	331,307	0	573,153	0	90.00
91.00	09100	EMERGENCY	0	839,584	0	1,744,099	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,028	13,394,409	-4,475,801	25,117,420	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	4,319	0	26,937	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	15,654	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	13,408	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	168,757	0	654,624	0	194.01
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)	6,654	4,796,785		4,475,801	0	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	CAPITAL RELATED COSTS MME STEELEVILLE (SQ FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (GROSS SALARIES)	
			2.02	4.00	5A	5.00	6.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	2.197490	0.353550		0.173292	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		19,462		361,978	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001434		0.014015	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	OPERATION OF PLANT (SQ FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQ FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-B&F CHESTER CLINIC						1.01
1.02	00102	CAP REL COSTS-B&F STEELEVILLE						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MME CHESTER CLINIC						2.01
2.02	00202	CAP REL COSTS-MME STEELEVILLE						2.02
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	59,690					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	713	880				8.00
9.00	00900	HOUSEKEEPING	1,441	0	57,536			9.00
10.00	01000	DIETARY	522	0	522	880		10.00
11.00	01100	CAFETERIA	2,446	0	2,446	0	7,765,496	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,824	0	1,824	0	325,633	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,200	0	1,200	0	131,234	14.00
15.00	01500	PHARMACY	1,281	0	1,281	0	335,772	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,324	0	1,324	0	467,368	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,488	880	9,488	880	2,021,558	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,415	0	8,415	0	756,355	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,189	0	5,189	0	698,773	54.00
60.00	06000	LABORATORY	2,347	0	2,347	0	828,007	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	144	0	144	0	26,582	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	53,460	64.00
65.00	06500	RESPIRATORY THERAPY	1,505	0	1,505	0	273,116	65.00
66.00	06600	PHYSICAL THERAPY	7,149	0	7,149	0	208,890	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,083	0	1,083	0	59,615	67.00
68.00	06800	SPEECH PATHOLOGY	570	0	570	0	31,680	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	2,166	0	2,166	0	202,098	76.01
76.02	03020	WOUND CARE	348	0	348	0	1,388	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT 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
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	3,497	0	3,497	0	331,307	90.00
91.00	09100	EMERGENCY	4,375	0	4,375	0	839,584	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	57,027	880	54,873	880	7,592,420	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	943	0	943	0	4,319	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	711	0	711	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	609	0	609	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	400	0	400	0	168,757	194.01
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)	1,840,211	193,073	861,543	264,907	845,856	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.829469	219.401136	14.973982	301.030682	0.108925	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	293,954	21,337	49,172	17,531	77,212	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	OPERATION OF PLANT (SQ FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQ FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	4.924678	24.246591	0.854630	19.921591	0.009943	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: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			12.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-B&F CHESTER CLINIC						1.01
1.02	00102	CAP REL COSTS-B&F STEELEVILLE						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MME CHESTER CLINIC						2.01
2.02	00202	CAP REL COSTS-MME STEELEVILLE						2.02
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
12.00	01200	MAINTENANCE OF PERSONNEL	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	3,873,055				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	785,221			14.00
15.00	01500	PHARMACY	0	0	0	2,378,859		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	48,916,212	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,021,558	21,906	0	1,934,744	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	756,355	34,261	0	2,895,407	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	9,025	0	12,298,675	54.00
60.00	06000	LABORATORY	0	0	0	0	11,417,338	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	504	0	216,669	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	53,460	0	0	298,829	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	6,260	0	1,803,330	65.00
66.00	06600	PHYSICAL THERAPY	0	0	410	0	2,053,131	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	311,008	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	163,639	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	498,783	0	4,614,674	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	181,172	0	340,894	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	337,439	1,937,232	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	202,098	11,354	2,041,420	4,245,774	76.01
76.02	03020	WOUND CARE	0	0	0	0	331,778	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT 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
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	4,100	0	532,359	90.00
91.00	09100	EMERGENCY	0	839,584	17,446	0	3,520,731	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,873,055	785,221	2,378,859	48,916,212	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	0	0	0	194.01
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)	0	754,078	335,853	716,885	964,486	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.194699	0.427718	0.301357	0.019717	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			12.00	13.00	14.00	15.00	16.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	0	61,991	38,032	46,852	52,306	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.016006	0.048435	0.019695	0.001069	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: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
			17.00	19.00	20.00	21.00	22.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-B&F CHESTER CLINIC						1.01
1.02	00102	CAP REL COSTS-B&F STEELEVILLE						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MME CHESTER CLINIC						2.01
2.02	00202	CAP REL COSTS-MME STEELEVILLE						2.02
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	0					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
20.00	02000	NURSING PROGRAM	0		0			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0			0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0				0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	0	0	0	0	76.01
76.02	03020	WOUND CARE	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT 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
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	0	0	0	194.01
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)	0	0	0	0	0	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
			17.00	19.00	20.00	21.00	22.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0			206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000			207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	PARAMED ED PRGM (ASSIGNED TIME)		
			23.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-B&F CHESTER CLINIC			1.01
1.02	00102	CAP REL COSTS-B&F STEELEVILLE			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	CAP REL COSTS-MME CHESTER CLINIC			2.01
2.02	00202	CAP REL COSTS-MME STEELEVILLE			2.02
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
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING PROGRAM			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
64.00	06400	INTRAVENOUS THERAPY	0		64.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	03950	CARDIAC REHAB	0		76.00
76.01	03951	CHEMOTHERAPY	0		76.01
76.02	03020	WOUND CARE	0		76.02
76.97	07697	CARDIAC REHABILITATION	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		76.98
76.99	07699	LITHOTRIPSY	0		76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		77.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0		88.01
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		192.00
193.01	19301	AFTER CARE PROGRAM	0		193.01
194.00	07950	NON-ALLOWABLE COSTS	0		194.00
194.01	07951	RETAIL PHARMACY	0		194.01
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)	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/28/2023 3:50 pm

		Cost Center Description	PARAMED ED PRGM (ASSIGNED TIME)		
			23.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/28/2023 3:50 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,315,572		5,315,572	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,350,004		2,350,004	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,430,048		2,430,048	0	0	54.00
60.00	06000	LABORATORY	3,182,591		3,182,591	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	144,665		144,665	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	111,710		111,710	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	664,431	0	664,431	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,123,650	0	1,123,650	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	187,875	0	187,875	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	102,511	0	102,511	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	889,409		889,409	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	296,780		296,780	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	535,800		535,800	0	0	73.00
76.00	03950	CARDIAC REHAB	0		0	0	0	76.00
76.01	03951	CHEMOTHERAPY	3,678,823		3,678,823	0	0	76.01
76.02	03020	WOUND CARE	144,244		144,244	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,711,621		4,711,621	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0		0	0	0	88.01
90.00	09000	CLINIC	880,990		880,990	0	0	90.00
91.00	09100	EMERGENCY	2,578,525		2,578,525	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	590,665		590,665		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	29,919,914	0	29,919,914	0	0	200.00
201.00		Less Observation Beds	590,665		590,665		0	201.00
202.00		Total (see instructions)	29,329,249	0	29,329,249	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I | Date/Time Prepared: 11/28/2023 3:50 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,677,254		1,677,254			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	173,348	2,722,059	2,895,407	0.811632	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	373,323	11,925,352	12,298,675	0.197586	0.000000	54.00
60.00	06000	LABORATORY	745,189	10,672,149	11,417,338	0.278751	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	52,037	164,632	216,669	0.667677	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	3,274	295,555	298,829	0.373826	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	260,560	1,542,770	1,803,330	0.368447	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	334,002	1,719,129	2,053,131	0.547286	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	137,565	173,443	311,008	0.604084	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	37,891	125,748	163,639	0.626446	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	673,894	3,940,780	4,614,674	0.192735	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,845	317,049	340,894	0.870593	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	415,317	1,521,915	1,937,232	0.276580	0.000000	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0.000000	0.000000	76.00
76.01	03951	CHEMOTHERAPY	7,722	4,238,052	4,245,774	0.866467	0.000000	76.01
76.02	03020	WOUND CARE	386	331,392	331,778	0.434761	0.000000	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	460,614	4,452,775	4,913,389			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0			88.01
90.00	09000	CLINIC	6,212	526,147	532,359	1.654880	0.000000	90.00
91.00	09100	EMERGENCY	31,092	3,489,639	3,520,731	0.732383	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	701	256,789	257,490	2.293934	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	5,414,226	48,415,375	53,829,601			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,414,226	48,415,375	53,829,601			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I | Date/Time Prepared: 11/28/2023 3:50 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	03950	CARDIAC REHAB	0.000000	76.00
76.01	03951	CHEMOTHERAPY	0.000000	76.01
76.02	03020	WOUND CARE	0.000000	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
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: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/28/2023 3:50 pm

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	5,315,572		5,315,572	0	5,315,572	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,350,004		2,350,004	0	2,350,004	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,430,048		2,430,048	0	2,430,048	54.00
60.00	06000	LABORATORY	3,182,591		3,182,591	0	3,182,591	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	144,665		144,665	0	144,665	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	111,710		111,710	0	111,710	64.00
65.00	06500	RESPIRATORY THERAPY	664,431	0	664,431	0	664,431	65.00
66.00	06600	PHYSICAL THERAPY	1,123,650	0	1,123,650	0	1,123,650	66.00
67.00	06700	OCCUPATIONAL THERAPY	187,875	0	187,875	0	187,875	67.00
68.00	06800	SPEECH PATHOLOGY	102,511	0	102,511	0	102,511	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	889,409		889,409	0	889,409	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	296,780		296,780	0	296,780	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	535,800		535,800	0	535,800	73.00
76.00	03950	CARDIAC REHAB	0		0	0	0	76.00
76.01	03951	CHEMOTHERAPY	3,678,823		3,678,823	0	3,678,823	76.01
76.02	03020	WOUND CARE	144,244		144,244	0	144,244	76.02
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,711,621		4,711,621	0	4,711,621	88.00
88.01	08801	RURAL HEALTH CLINIC II	0		0	0	0	88.01
90.00	09000	CLINIC	880,990		880,990	0	880,990	90.00
91.00	09100	EMERGENCY	2,578,525		2,578,525	0	2,578,525	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	590,665		590,665		590,665	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	29,919,914	0	29,919,914	0	29,919,914	200.00
201.00		Less Observation Beds	590,665		590,665		590,665	201.00
202.00		Total (see instructions)	29,329,249	0	29,329,249	0	29,329,249	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/28/2023 3:50 pm

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	1,677,254		1,677,254			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	173,348	2,722,059	2,895,407	0.811632	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	373,323	11,925,352	12,298,675	0.197586	0.000000	54.00
60.00	06000	LABORATORY	745,189	10,672,149	11,417,338	0.278751	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	52,037	164,632	216,669	0.667677	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	3,274	295,555	298,829	0.373826	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	260,560	1,542,770	1,803,330	0.368447	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	334,002	1,719,129	2,053,131	0.547286	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	137,565	173,443	311,008	0.604084	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	37,891	125,748	163,639	0.626446	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	673,894	3,940,780	4,614,674	0.192735	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,845	317,049	340,894	0.870593	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	415,317	1,521,915	1,937,232	0.276580	0.000000	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0.000000	0.000000	76.00
76.01	03951	CHEMOTHERAPY	7,722	4,238,052	4,245,774	0.866467	0.000000	76.01
76.02	03020	WOUND CARE	386	331,392	331,778	0.434761	0.000000	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	460,614	4,452,775	4,913,389	0.958935	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0.000000	0.000000	88.01
90.00	09000	CLINIC	6,212	526,147	532,359	1.654880	0.000000	90.00
91.00	09100	EMERGENCY	31,092	3,489,639	3,520,731	0.732383	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	701	256,789	257,490	2.293934	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	5,414,226	48,415,375	53,829,601			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,414,226	48,415,375	53,829,601			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I | Date/Time Prepared: 11/28/2023 3:50 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	03950	CARDIAC REHAB	0.000000		76.00
76.01	03951	CHEMOTHERAPY	0.000000		76.01
76.02	03020	WOUND CARE	0.000000		76.02
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
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: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 11/28/2023 3:50 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	279,232	2,895,407	0.096440	65,649	6,331	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	188,116	12,298,675	0.015296	116,145	1,777	54.00
60.00	06000	LABORATORY	119,828	11,417,338	0.010495	244,102	2,562	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,122	216,669	0.028255	26,370	745	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	2,854	298,829	0.009551	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	53,472	1,803,330	0.029652	87,543	2,596	65.00
66.00	06600	PHYSICAL THERAPY	212,056	2,053,131	0.103284	41,150	4,250	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,614	311,008	0.104865	15,694	1,646	67.00
68.00	06800	SPEECH PATHOLOGY	17,212	163,639	0.105183	6,148	647	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	36,081	4,614,674	0.007819	248,253	1,941	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,678	340,894	0.034257	23,845	817	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,446	1,937,232	0.006941	123,280	856	73.00
76.00	03950	CARDIAC REHAB	0	0	0.000000	0	0	76.00
76.01	03951	CHEMOTHERAPY	144,653	4,245,774	0.034070	0	0	76.01
76.02	03020	WOUND CARE	11,496	331,778	0.034650	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	124,241	4,913,389	0.025286	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0.000000	0	0	88.01
90.00	09000	CLINIC	109,772	532,359	0.206199	5,927	1,222	90.00
91.00	09100	EMERGENCY	173,648	3,520,731	0.049322	784	39	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	45,116	257,490	0.175215	0	0	92.00
200.00		Total (lines 50 through 199)	1,581,637	52,152,347		1,004,890	25,429	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/28/2023 3:50 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	0	0	0	0	76.01
76.02	03020	WOUND CARE	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT 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
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
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: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/28/2023 3:50 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	2,895,407	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,298,675	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	11,417,338	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	216,669	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	298,829	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,803,330	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,053,131	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	311,008	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	163,639	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,614,674	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	340,894	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,937,232	0.000000	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0.000000	76.00
76.01	03951	CHEMOTHERAPY	0	0	0	4,245,774	0.000000	76.01
76.02	03020	WOUND CARE	0	0	0	331,778	0.000000	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,913,389	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0.000000	88.01
90.00	09000	CLINIC	0	0	0	532,359	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	3,520,731	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	257,490	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	52,152,347		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/28/2023 3:50 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	65,649	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	116,145	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	244,102	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	26,370	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	87,543	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	41,150	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	15,694	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	6,148	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	248,253	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	23,845	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	123,280	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0.000000	0	0	0	0	76.01
76.02	03020	WOUND CARE	0.000000	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT 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
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	5,927	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	784	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,004,890	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/28/2023 3:50 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.811632	0	793,401	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197586	0	2,909,811	0	0	54.00
60.00	06000	LABORATORY	0.278751	0	2,842,853	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.667677	0	53,859	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.373826	0	126,673	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.368447	0	433,038	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.547286	0	575,442	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.604084	0	47,970	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.626446	0	27,395	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.192735	0	1,096,893	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.870593	0	95,234	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276580	0	405,489	71	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0.866467	0	1,753,265	399	0	76.01
76.02	03020	WOUND CARE	0.434761	0	145,876	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	1.654880	0	163,391	0	0	90.00
91.00	09100	EMERGENCY	0.732383	0	740,230	3,889	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.293934	0	95,210	0	0	92.00
200.00		Subtotal (see instructions)		0	12,306,030	4,359	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	12,306,030	4,359	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/28/2023 3:50 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	643,950	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	574,938	0		54.00
60.00	06000	LABORATORY	792,448	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	35,960	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400	INTRAVENOUS THERAPY	47,354	0		64.00
65.00	06500	RESPIRATORY THERAPY	159,552	0		65.00
66.00	06600	PHYSICAL THERAPY	314,931	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	28,978	0		67.00
68.00	06800	SPEECH PATHOLOGY	17,161	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	211,410	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	82,910	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	112,150	20		73.00
76.00	03950	CARDIAC REHAB	0	0		76.00
76.01	03951	CHEMOTHERAPY	1,519,146	346		76.01
76.02	03020	WOUND CARE	63,421	0		76.02
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
90.00	09000	CLINIC	270,392	0		90.00
91.00	09100	EMERGENCY	542,132	2,848		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	218,405	0		92.00
200.00		Subtotal (see instructions)	5,635,238	3,214		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,635,238	3,214		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/28/2023 3:50 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.811632	0	46,814	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197586	0	345,956	0	0	54.00
60.00	06000	LABORATORY	0.278751	0	197,921	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.667677	0	1,958	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.373826	0	54,274	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.368447	0	26,431	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.547286	0	25,887	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.604084	0	725	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.626446	0	3,864	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.192735	0	18,537	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.870593	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276580	0	34,423	0	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0.866467	0	697	0	0	76.01
76.02	03020	WOUND CARE	0.434761	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	1.654880	0	3,847	0	0	90.00
91.00	09100	EMERGENCY	0.732383	0	153,891	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.293934	0	6,868	0	0	92.00
200.00		Subtotal (see instructions)		0	922,093	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	922,093	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/28/2023 3:50 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	37,996	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	68,356	0		54.00
60.00	06000	LABORATORY	55,171	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,307	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400	INTRAVENOUS THERAPY	20,289	0		64.00
65.00	06500	RESPIRATORY THERAPY	9,738	0		65.00
66.00	06600	PHYSICAL THERAPY	14,168	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	438	0		67.00
68.00	06800	SPEECH PATHOLOGY	2,421	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,573	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,521	0		73.00
76.00	03950	CARDIAC REHAB	0	0		76.00
76.01	03951	CHEMOTHERAPY	604	0		76.01
76.02	03020	WOUND CARE	0	0		76.02
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
90.00	09000	CLINIC	6,366	0		90.00
91.00	09100	EMERGENCY	112,707	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	15,755	0		92.00
200.00		Subtotal (see instructions)	358,410	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	358,410	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/28/2023 3:50 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,786	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,069	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)	880	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	299	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)	327	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	60	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)	31	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	401	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)	250	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)	189	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	201.56	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	201.56	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,315,572	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)	12,094	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)	6,248	25.00
26.00	Total swing-bed cost (see instructions)	1,974,723	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,340,849	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)	3,340,849	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	3,125.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,253,209	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)	1,253,209	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/28/2023 3:50 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	343,075	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,596,284	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)	781,303	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	590,665	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	1,371,968	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)	189	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,125.21	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1338	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/28/2023 3:50 pm
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	590,665	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	406,007	5,315,572	0.076381	590,665	45,116	90.00
91.00	Nursing Program cost	0	5,315,572	0.000000	590,665	0	91.00
92.00	Allied health cost	0	5,315,572	0.000000	590,665	0	92.00
93.00	All other Medical Education	0	5,315,572	0.000000	590,665	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/28/2023 3:50 pm

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)	1,786	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,069	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)	880	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	299	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)	327	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	60	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)	31	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1	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	201.56	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	201.56	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,315,572	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)	12,094	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)	6,248	25.00
26.00	Total swing-bed cost (see instructions)	1,974,723	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,340,849	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)	3,340,849	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	3,125.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,125	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,125	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/28/2023 3:50 pm

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	8,973	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)	12,098	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)	189	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,125.21	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1338	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/28/2023 3:50 pm
	Title XIX	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	590,665	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	406,007	5,315,572	0.076381	590,665	45,116	90.00
91.00	Nursing Program cost	0	5,315,572	0.000000	590,665	0	91.00
92.00	Allied health cost	0	5,315,572	0.000000	590,665	0	92.00
93.00	All other Medical Education	0	5,315,572	0.000000	590,665	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/28/2023 3:50 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		451,847		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.811632	65,649	53,283	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197586	116,145	22,949	54.00
60.00	06000	LABORATORY	0.278751	244,102	68,044	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.667677	26,370	17,607	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.373826	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.368447	87,543	32,255	65.00
66.00	06600	PHYSICAL THERAPY	0.547286	41,150	22,521	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.604084	15,694	9,480	67.00
68.00	06800	SPEECH PATHOLOGY	0.626446	6,148	3,851	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.192735	248,253	47,847	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.870593	23,845	20,759	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276580	123,280	34,097	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	76.00
76.01	03951	CHEMOTHERAPY	0.866467	0	0	76.01
76.02	03020	WOUND CARE	0.434761	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	1.654880	5,927	9,808	90.00
91.00	09100	EMERGENCY	0.732383	784	574	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.293934	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,004,890	343,075	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)		1,004,890		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1338 | Component CCN: 14-Z338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/28/2023 3:50 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.811632	2,966	2,407	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197586	28,141	5,560	54.00
60.00	06000	LABORATORY	0.278751	80,155	22,343	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.667677	2,368	1,581	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.373826	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.368447	28,967	10,673	65.00
66.00	06600	PHYSICAL THERAPY	0.547286	151,882	83,123	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.604084	66,975	40,459	67.00
68.00	06800	SPEECH PATHOLOGY	0.626446	20,898	13,091	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.192735	78,519	15,133	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.870593	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276580	55,918	15,466	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	76.00
76.01	03951	CHEMOTHERAPY	0.866467	0	0	76.01
76.02	03020	WOUND CARE	0.434761	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	1.654880	285	472	90.00
91.00	09100	EMERGENCY	0.732383	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.293934	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		517,074	210,308	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)		517,074		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/28/2023 3:50 pm

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		886		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.811632	8,761	7,111	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197586	0	0	54.00
60.00	06000	LABORATORY	0.278751	660	184	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.667677	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.373826	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.368447	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.547286	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.604084	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.626446	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.192735	6,471	1,247	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.870593	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.276580	1,557	431	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	76.00
76.01	03951	CHEMOTHERAPY	0.866467	0	0	76.01
76.02	03020	WOUND CARE	0.434761	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.958935	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	88.01
90.00	09000	CLINIC	1.654880	0	0	90.00
91.00	09100	EMERGENCY	0.732383	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.293934	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		17,449	8,973	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)		17,449		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1338	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/28/2023 3:50 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,638,452	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,638,452	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	5,694,837	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)	29,100	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,863,239	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,802,498	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	3,802,498	30.00
31.00	Primary payer payments	1,351	31.00
32.00	Subtotal (line 30 minus line 31)	3,801,147	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)	144,990	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	94,244	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	118,350	36.00
37.00	Subtotal (see instructions)	3,895,391	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)	3,895,391	40.00
40.01	Sequestration adjustment (see instructions)	77,908	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	3,610,583	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)	206,900	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1338	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/28/2023 3:50 pm
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2023 3:50 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,256,418		3,575,133	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	02/15/2023	175,881	02/15/2023	33,795	3.01
3.02		06/15/2023	143,496	06/15/2023	1,655	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)		319,377		35,450	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,575,795		3,610,583	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		206,900	6.01
6.02	SETTLEMENT TO PROGRAM		115,551		0	6.02
7.00	Total Medicare program liability (see instructions)		1,460,244		3,817,483	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: 14-1338 | Component CCN: 14-Z338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2023 3:50 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,338,544		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/15/2023	143,043		0	3.01
3.02		06/15/2023	82,557		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		225,600		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,564,144		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		3,382		0	6.02
7.00	Total Medicare program liability (see instructions)		1,560,762		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1338	Period: From 07/01/2022 To 06/30/2023	Worksheet E-1 Part II Date/Time Prepared: 11/28/2023 3:50 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1338 | Component CCN: 14-Z338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-2 | Date/Time Prepared: 11/28/2023 3:50 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,385,688	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	212,411	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	439	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,598,099	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,598,099	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,598,099	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,485	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,592,614	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,592,614	0	19.00
19.01	Sequestration adjustment (see instructions)	31,852	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	1,564,144	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	-3,382	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1338	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part V Date/Time Prepared: 11/28/2023 3:50 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,596,284	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	1,596,284	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,612,247	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,612,247	19.00
20.00	Deductibles (exclude professional component)	139,980	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,472,267	22.00
23.00	Coinsurance	1,167	23.00
24.00	Subtotal (line 22 minus line 23)	1,471,100	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	29,146	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	18,945	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	27,590	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,490,045	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,490,045	30.00
30.01	Sequestration adjustment (see instructions)	29,801	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,575,795	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)	-115,551	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1338	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 11/28/2023 3:50 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	12,098		1.00
2.00	Medical and other services		358,410	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	12,098	358,410	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	12,098	358,410	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	17,449	922,093	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	17,449	922,093	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	17,449	922,093	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	5,351	563,683	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	12,098	358,410	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	12,098	358,410	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	12,098	358,410	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	12,098	358,410	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	12,098	358,410	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	12,098	358,410	40.00
41.00	Interim payments	12,098	358,410	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G | Date/Time Prepared: 11/28/2023 3:50 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3,793,086	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	9,050,028	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,636,884	0	0	0	6.00
7.00	Inventory	509,366	0	0	0	7.00
8.00	Prepaid expenses	987,177	0	0	0	8.00
9.00	Other current assets	558,113	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)	9,260,886	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	232,983	0	0	0	12.00
13.00	Land improvements	724,211	0	0	0	13.00
14.00	Accumulated depreciation	-643,077	0	0	0	14.00
15.00	Buildings	24,426,074	0	0	0	15.00
16.00	Accumulated depreciation	-12,508,781	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	1,228,415	0	0	0	19.00
20.00	Accumulated depreciation	-951,209	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	12,701,524	0	0	0	23.00
24.00	Accumulated depreciation	-11,456,543	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	1,687,027	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	15,440,624	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	41,155,415	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	41,155,415	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	65,856,925	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,154,530	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	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	3,203,957	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,358,487	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,358,487	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	61,498,438				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)	61,498,438	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	65,856,925	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-1 | Date/Time Prepared: 11/28/2023 3:50 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		59,385,174		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,113,264				2.00
3.00	Total (sum of line 1 and line 2)		61,498,438		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)		61,498,438		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)		61,498,438		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: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/28/2023 3:50 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	975,015		975,015	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	555,045		555,045	5.00
6.00	Swing bed - NF	80,685		80,685	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,610,745		1,610,745	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,610,745		1,610,745	17.00
18.00	Ancillary services	3,235,752	38,810,575	42,046,327	18.00
19.00	Outpatient services	31,185	4,345,904	4,377,089	19.00
20.00	RURAL HEALTH CLINIC	460,614	5,335,938	5,796,552	20.00
20.01	RURAL HEALTH CLINIC II	0	0	0	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	34,221	4,439,166	4,473,387	27.00
27.01	RETAIL PHARMACY	0	2,505,228	2,505,228	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,372,517	55,436,811	60,809,328	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		34,416,613		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)		34,416,613		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1338 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-3 | Date/Time Prepared: 11/28/2023 3:50 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	60,809,328	1.00
2.00	Less contractual allowances and discounts on patients' accounts	26,687,423	2.00
3.00	Net patient revenues (line 1 minus line 2)	34,121,905	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	34,416,613	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-294,708	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	967,507	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	49,876	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	64,657	17.00
18.00	Revenue from sale of medical records and abstracts	9,368	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	340B RETAILPHARMACY NET REV	965,578	24.00
24.01	OTHER OPER REV - BUS UNIT 5000	40,016	24.01
24.02	OTHER NON OP REV	310,970	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	2,407,972	25.00
26.00	Total (line 5 plus line 25)	2,113,264	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)	2,113,264	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1338 | Component CCN: 14-8543 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/28/2023 3:50 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,548,565	544,084	2,092,649	-878,773	1,213,876	1.00
2.00	Physician Assistant	108,526	36,849	145,375	-31,868	113,507	2.00
3.00	Nurse Practitioner	236,840	80,416	317,256	-65,924	251,332	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	681,748	231,478	913,226	-189,764	723,462	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	92,089	31,268	123,357	-25,633	97,724	8.00
9.00	Other Facility Health Care Staff Costs	151,277	51,364	202,641	-42,108	160,533	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,819,045	975,459	3,794,504	-1,234,070	2,560,434	10.00
11.00	Physician Services Under Agreement	0	975,438	975,438	0	975,438	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	975,438	975,438	0	975,438	14.00
15.00	Medical Supplies	0	26,258	26,258	0	26,258	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	71,659	71,659	-71,659	0	18.00
19.00	Other Health Care Costs	0	189,159	189,159	-31,732	157,427	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	287,076	287,076	-103,391	183,685	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,819,045	2,237,973	5,057,018	-1,337,461	3,719,557	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	265	265	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	265	265	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	159,738	159,738	-64,276	95,462	29.00
30.00	Administrative Costs	519,838	255,481	775,319	-580,698	194,621	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	519,838	415,219	935,057	-644,974	290,083	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,338,883	2,653,192	5,992,075	-1,982,170	4,009,905	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1338 | Component CCN: 14-8543 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/28/2023 3:50 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,213,876		1.00
2.00	Physician Assistant	0	113,507		2.00
3.00	Nurse Practitioner	0	251,332		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	723,462		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	97,724		8.00
9.00	Other Facility Health Care Staff Costs	0	160,533		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,560,434		10.00
11.00	Physician Services Under Agreement	-965,967	9,471		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)	-965,967	9,471		14.00
15.00	Medical Supplies	0	26,258		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	157,427		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	183,685		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-965,967	2,753,590		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	265		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	265		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	95,462		29.00
30.00	Administrative Costs	0	194,621		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	290,083		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-965,967	3,043,938		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1338 | Component CCN: 14-8543 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-2 | Date/Time Prepared: 11/28/2023 3:50 pm

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	3.39	12,940	4,200	14,238		1.00
2.00	Physician Assistant	0.77	2,020	2,100	1,617		2.00
3.00	Nurse Practitioner	1.67	4,014	2,100	3,507		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.83	18,974		19,362	19,362	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.83	18,974			19,362	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)					2,753,590	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					265	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,753,855	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999904	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					290,083	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,667,683	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,957,766	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,957,766	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,957,578	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,711,168	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1338 Component CCN: 14-8543	Period: From 07/01/2022 To 06/30/2023	Worksheet M-3 Date/Time Prepared: 11/28/2023 3:50 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			4,711,168	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			164,593	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			4,546,575	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			19,362	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)			19,362	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			234.82	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)	216.40	224.62		8.00
9.00	Rate for Program covered visits (see instructions)	216.40	224.62		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	2,356	2,393		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	509,838	537,516		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,047,354		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,008,076		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,940		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		5,132		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.)		749,878		16.04
16.05	Total program cost (see instructions)	0	755,010		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		104,875		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		178,020		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		755,010		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		51,820		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		806,830		22.00
23.00	Allowable bad debts (see instructions)		35,835		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		23,293		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		32,710		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)		830,123		26.00
26.01	Sequestration adjustment (see instructions)		16,602		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		702,941		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)		110,580		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1338 | Component CCN: 14-8543 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-4 | Date/Time Prepared: 11/28/2023 3:50 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,560,434	2,560,434	2,560,434	2,560,434	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002350	0.013758	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	6,017	35,226	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	10,363	44,595	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	16,380	79,821	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,753,590	2,753,590	2,753,590	2,753,590	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,957,578	1,957,578	1,957,578	1,957,578	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.005949	0.028988	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	11,646	56,746	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	28,026	136,567	0	0	10.00
11.00	Total number of injections/infusions (from your records)	171	1,001	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	163.89	136.43	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	24	351	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)	3,933	47,887	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)		164,593	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)		51,820	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1338 Component CCN: 14-8543	Period: From 07/01/2022 To 06/30/2023	Worksheet M-5 Date/Time Prepared: 11/28/2023 3:50 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		702,733	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		02/15/2023	71	3.01
3.02		02/15/2023	137	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)		208	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		702,941	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		110,580	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		813,521	7.00

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