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: 14-1342	Period: From 01/14/2023 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/27/2024 3:24 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/27/2024 Time: 3:24 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 UNION COUNTY HOSPITAL DISTRICT (14-1342) for the cost reporting period beginning 01/14/2023 and ending 09/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Amber Lipe		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Amber Lipe			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	533,205	-448,785	0	-2,689	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	542,344	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-25,042		0	10.00
200.00	TOTAL	0	1,075,549	-473,827	0	-2,689	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2024 3:24 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 517 NORTH MAIN STREET	PO Box:			1.00
2.00	City: ANNA	State: IL	Zip Code: 62906	County: UNION	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	UNION COUNTY HOSPITAL DISTRICT	141342	99914	1	07/01/1966	N	O	P	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	UNION COUNTY HOSP DIST SWING BEDS	14Z342	99914		08/05/1992	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	UNION COUNTY HOSP DIST RHC	143975	99914		05/22/1991	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/14/2023	09/30/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N			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: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2024 3:24 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: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2024 3:24 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)				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: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2024 3:24 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2024 3:24 pm

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

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2024 3:24 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2024 3:24 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	N	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0778	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: DEACONESS HEALTH SYSTEM	Contractor's Name: WISCONSIN PHYSICAN SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 600 MARY STREET	PO Box:		142.00
143.00	City: EVANSVILLE	State: IN	Zip Code: 47710	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: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2024 3:24 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	Y	Y	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
					1.00	
	Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

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

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		1.00	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: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/27/2024 3:24 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)	Y	01/14/2023	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)	Y			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)	Y	02/01/2024	Y	02/01/2024	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)	N		N		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: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/27/2024 3:24 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.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		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.	Y		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.	AUSTIN	FISHER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	AFISHER@BLUEANDCO.COM	3172757438	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1342	Period: From 01/14/2023 To 09/30/2023	Worksheet S-2 Part II Date/Time Prepared: 2/27/2024 3:24 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.	SENIOR MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 2/27/2024 3:24 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	6,500	22,632.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	6,500	22,632.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	6,500	22,632.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	22	5,720			21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		47				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: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2024 3:24 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)	480	4	943			1.00
2.00	HMO and other (see instructions)	171	72				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	639	0	639			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	509			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,119	4	2,091			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,119	4	2,091	0.00	55.50	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			685	0.00	5.99	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	530	0	4,991	0.00	2.82	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	64.31	27.00
28.00	Observation Bed Days		53	303			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: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2024 3:24 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	129	1	275	1.00
2.00	HMO and other (see instructions)			46	24		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	129	1	275	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	0.00				0	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	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: 14-1342 | Component CCN: 14-3975 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/27/2024 3:24 pm

			RHC I	Cost
			1.00	
	Clinic Address and Identification			
1.00	Street		517 NORTH MAIN STREET	1.00
		City	State	ZIP Code
		1.00	2.00	3.00
2.00	City, State, ZIP Code, County	ANNA	IL	62906 2.00
				1.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00
		Grant Award		Date
		1.00		2.00
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00
			1.00	2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0 10.00

		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			08:00	17:00	08:00 11.00
					1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?				N	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0 13.00
				Provider name		CCN
				1.00		2.00
14.00	RHC/FQHC name, CCN					14.00

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

			County			
			4.00			
2.00	City, State, ZIP Code, County		UNION			2.00

		Tuesday	Wednesday		Thursday	
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
	Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00 11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1342
Component CCN: 14-3975

Period:
From 01/14/2023
To 09/30/2023

Worksheet S-8
Date/Time Prepared:
2/27/2024 3:24 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	09:00	16:50		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 2/27/2024 3:24 pm

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.266505	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,015,963	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	1,034,667	5.00
6.00	Medicaid charges	19,590,725	6.00
7.00	Medicaid cost (line 1 times line 6)	5,221,026	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	2,170,396	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,170,396	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	697,944	0	697,944	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	186,006	0	186,006	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	186,006	0	186,006	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	96,621	26.00
27.00	Medicare reimbursable bad debts (see instructions)	62,804	27.00
27.01	Medicare allowable bad debts (see instructions)	96,621	27.01
28.00	Non-Medicare bad debt amount (see instructions)	0	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	33,817	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	219,823	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,390,219	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 2/27/2024 3:24 pm

		1.00	
	PART II - HOSPITAL DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)		1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		5.00
6.00	Medicaid charges		6.00
7.00	Medicaid cost (line 1 times line 6)		7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP		9.00
10.00	Stand-alone CHIP charges		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)				20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)				21.00
22.00	Payments received from patients for amounts previously written off as charity care				22.00
23.00	Cost of charity care (see instructions)				23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		25.00
25.01	Charges for insured patients' liability (see instructions)		25.01
26.00	Bad debt amount (see instructions)		26.00
27.00	Medicare reimbursable bad debts (see instructions)		27.00
27.01	Medicare allowable bad debts (see instructions)		27.01
28.00	Non-Medicare bad debt amount (see instructions)		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/27/2024 3:24 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		0	0	241,047	241,047	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		499,017	499,017	0	499,017	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	56,075	18,710	74,785	346,999	421,784	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	252,416	252,416	49,457	301,873	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	213,042	7,238,938	7,451,980	-621,795	6,830,185	5.02
7.00	00700	OPERATION OF PLANT	139,219	1,168,877	1,308,096	0	1,308,096	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,636	151,091	152,727	0	152,727	8.00
9.00	00900	HOUSEKEEPING	205,500	60,546	266,046	0	266,046	9.00
10.00	01000	DIETARY	0	470,662	470,662	0	470,662	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	558,080	56,066	614,146	-197,397	416,749	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	108,242	189,780	298,022	-115,029	182,993	14.00
15.00	01500	PHARMACY	251,339	430,880	682,219	-327,703	354,516	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,138	4,138	0	4,138	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,078,330	773,539	1,851,869	198,850	2,050,719	30.00
46.00	04600	OTHER LONG TERM CARE	416,715	104,882	521,597	0	521,597	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	250,524	158,113	408,637	-9,486	399,151	50.00
51.00	05100	RECOVERY ROOM	53,997	7,635	61,632	0	61,632	51.00
53.00	05300	ANESTHESIOLOGY	0	216,469	216,469	0	216,469	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	373,371	253,523	626,894	335,855	962,749	54.00
54.01	05401	ULTRASOUND	57,498	11,204	68,702	-68,702	0	54.01
56.00	05600	RADIOISOTOPE	0	61,539	61,539	-61,539	0	56.00
57.00	05700	CT SCAN	53,673	56,126	109,799	-109,799	0	57.00
58.00	05800	MRI	49,167	46,648	95,815	-95,815	0	58.00
60.00	06000	LABORATORY	323,709	659,599	983,308	0	983,308	60.00
65.00	06500	RESPIRATORY THERAPY	44,546	40,068	84,614	-29,846	54,768	65.00
66.00	06600	PHYSICAL THERAPY	183,575	24,007	207,582	0	207,582	66.00
67.00	06700	OCCUPATIONAL THERAPY	288,573	21,882	310,455	0	310,455	67.00
68.00	06800	SPEECH PATHOLOGY	68,429	6,091	74,520	0	74,520	68.00
69.00	06900	ELECTROCARDIOLOGY	90,152	51,576	141,728	0	141,728	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	134,883	134,883	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,478	19,478	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	327,703	327,703	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	319,911	319,911	0	319,911	76.01
76.03	03950	WOUND CARE	2,004	3,783	5,787	0	5,787	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	333,994	79,091	413,085	-49,457	363,628	88.00
91.00	09100	EMERGENCY	841,720	1,138,557	1,980,277	0	1,980,277	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,043,110	14,575,364	20,618,474	-32,296	20,586,178	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
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	0	0	32,296	32,296	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	6,043,110	14,575,364	20,618,474	0	20,618,474	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/27/2024 3:24 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	-181,298	59,749		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	499,017		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	619,686	1,041,470		4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	301,873		5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	-2,998,106	3,832,079		5.02
7.00	00700	OPERATION OF PLANT	204,245	1,512,341		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	89,278	242,005		8.00
9.00	00900	HOUSEKEEPING	0	266,046		9.00
10.00	01000	DIETARY	51,175	521,837		10.00
11.00	01100	CAFETERIA	-24,180	-24,180		11.00
13.00	01300	NURSING ADMINISTRATION	141,422	558,171		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	182,993		14.00
15.00	01500	PHARMACY	142,659	497,175		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,952	7,090		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,352	2,048,367		30.00
46.00	04600	OTHER LONG TERM CARE	0	521,597		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	399,151		50.00
51.00	05100	RECOVERY ROOM	0	61,632		51.00
53.00	05300	ANESTHESIOLOGY	0	216,469		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	962,749		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	983,308		60.00
65.00	06500	RESPIRATORY THERAPY	0	54,768		65.00
66.00	06600	PHYSICAL THERAPY	0	207,582		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	310,455		67.00
68.00	06800	SPEECH PATHOLOGY	0	74,520		68.00
69.00	06900	ELECTROCARDIOLOGY	0	141,728		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	134,883		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,478		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	327,703		73.00
76.00	03610	SLEEP LAB	0	0		76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	319,911		76.01
76.03	03950	WOUND CARE	0	5,787		76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	206,581	570,209		88.00
91.00	09100	EMERGENCY	0	1,980,277		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,747,938	18,838,240		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
194.00	07956	AREAS UNDER RENOVATION	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	32,296		194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0		194.02
194.03	07953	FREESTANDING HHA COSTS	0	0		194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0		194.04
194.05	07955	VACANT SPACE	0	0		194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,747,938	18,870,536		200.00

RECLASSIFICATIONS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/27/2024 3:24 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	346,999	1.00
	0		0	346,999	
	B - OXYGEN RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	29,846	1.00
	0		0	29,846	
	C - OTHER CAPITAL COSTS RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	241,047	1.00
	0		0	241,047	
	D - MARKETING RECLASS				
1.00	OTHER NONREIMBURSABLE - MARKETING	194.01	0	32,296	1.00
	0		0	32,296	
	E - MEDICAL SUPPLIES RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	105,037	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	19,478	2.00
	0		0	124,515	
	F - DRUGS/IV SOLUTIONS RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	327,703	1.00
	0		0	327,703	
	G - RADIOLOGY RECLASS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	160,338	175,517	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		160,338	175,517	
	I - RHC ADMIN RECLASS				
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.01	49,457	0	1.00
	0		49,457	0	
	J - INFECTION CONTROL RECLASS				
1.00	NURSING ADMINISTRATION	13.00	0	1,453	1.00
	0		0	1,453	
	K - HOUSE SUPERVISOR RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	198,850	0	1.00
	0		198,850	0	
500.00	Grand Total: Increases		408,645	1,279,376	500.00

RECLASSIFICATIONS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/27/2024 3:24 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	346,999	0		1.00
	0		0	346,999			
	B - OXYGEN RECLASS						
1.00	RESPIRATORY THERAPY	65.00	0	29,846	0		1.00
	0		0	29,846			
	C - OTHER CAPITAL COSTS RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	241,047	12		1.00
	0		0	241,047			
	D - MARKETING RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	32,296	0		1.00
	0		0	32,296			
	E - MEDICAL SUPPLIES RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	115,029	0		1.00
2.00	OPERATING ROOM	50.00	0	9,486	0		2.00
	0		0	124,515			
	F - DRUGS/IV SOLUTIONS RECLASS						
1.00	PHARMACY	15.00	0	327,703	0		1.00
	0		0	327,703			
	G - RADIOLOGY RECLASS						
1.00	ULTRASOUND	54.01	57,498	11,204	0		1.00
2.00	RADIOISOTOPE	56.00	0	61,539	0		2.00
3.00	CT SCAN	57.00	53,673	56,126	0		3.00
4.00	MRI	58.00	49,167	46,648	0		4.00
	0		160,338	175,517			
	I - RHC ADMIN RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	49,457	0	0		1.00
	0		49,457	0			
	J - INFECTION CONTROL RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	1,453	0		1.00
	0		0	1,453			
	K - HOUSE SUPERVISOR RECLASS						
1.00	NURSING ADMINISTRATION	13.00	198,850	0	0		1.00
	0		198,850	0			
500.00	Grand Total: Decreases		408,645	1,279,376			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 2/27/2024 3:24 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	0	0	0	0	0	1.00
2.00	Land Improvements	47,473	0	0	0	47,473	2.00
3.00	Buildings and Fixtures	7,978,791	0	0	0	7,978,791	3.00
4.00	Building Improvements	16,076,740	0	0	0	12,405,822	4.00
5.00	Fixed Equipment	1,779,634	0	0	0	1,779,634	5.00
6.00	Movable Equipment	8,120,477	0	0	0	3,880,670	6.00
7.00	HIT designated Assets	3,186,190	0	0	0	3,186,190	7.00
8.00	Subtotal (sum of lines 1-7)	37,189,305	0	0	0	29,278,580	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	37,189,305	0	0	0	29,278,580	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	3,670,918	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	4,239,807	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	7,910,725	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	7,910,725	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-7 Part II Date/Time Prepared: 2/27/2024 3:24 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	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	499,017	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	499,017	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	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	499,017	2.00
3.00	Total (sum of lines 1-2)	0	499,017	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-7 Part III | Date/Time Prepared: 2/27/2024 3:24 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	0	0	0	0.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,910,725	0	7,910,725	1.000000	0	2.00
3.00	Total (sum of lines 1-2)	7,910,725	0	7,910,725	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	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	499,017	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	499,017	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	59,749	0	0	59,749	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	499,017	2.00
3.00	Total (sum of lines 1-2)	0	59,749	0	0	558,766	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/27/2024 3:24 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)	A	-181,298	CAP REL COSTS-BLDG & FIXT	1.00	12	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		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	-367,762			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	7,422			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-24,180	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-574	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/27/2024 3:24 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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	FITNESS REVENUE	B	-4,580	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.00
33.01	IL PROVIDER TAX	B	-1,034,667	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.01
33.03	CHARITABLE CONTRIBUTIONS	A	-4,016	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.03
33.06	MARKETING EXPENSE - EXCLUDING MARKET	A	-100	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.06
33.07	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-4,893	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.07
33.08	MISCELLANEOUS INCOME	B	-133,290	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.08
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,747,938				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/27/2024 3:24 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS DEPARTMENT	619,686	0	1.00
2.00	5.02	OTHER ADMINISTRATIVE AND GEN	ADMINISTRATIVE & GENERAL	1,151,680	2,968,240	2.00
3.00	7.00	OPERATION OF PLANT	MAINTENANCE	204,245	0	3.00
3.01	8.00	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	89,278	0	3.01
3.02	10.00	DIETARY	DIETARY	51,175	0	3.02
3.03	13.00	NURSING ADMINISTRATION	NURSING ADMIN	141,422	0	3.03
3.04	15.00	PHARMACY	PHARMACY	142,659	0	3.04
4.00	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS & LIBRARY	3,526	0	4.00
4.01	50.00	OPERATING ROOM	SURGERY	365,410	0	4.01
4.02	88.00	RURAL HEALTH CLINIC	RHC	206,581	0	4.02
4.03	0.00			0	0	4.03
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,975,662	2,968,240	5.00

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

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

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

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

6.00	B		0.00	DEACONESS HOSPI	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/27/2024 3:24 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	619,686	0		1.00
2.00	-1,816,560	0		2.00
3.00	204,245	9		3.00
3.01	89,278	9		3.01
3.02	51,175	0		3.02
3.03	141,422	0		3.03
3.04	142,659	0		3.04
4.00	3,526	0		4.00
4.01	365,410	0		4.01
4.02	206,581	0		4.02
4.03	0	0		4.03
5.00	7,422			5.00

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

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

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

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

6.00	HOSPITAL MANAGE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 2/27/2024 3:24 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	ADULTS & PEDIATRICS	569,828	2,352	567,476	0	0	1.00
2.00	50.00	OPERATING ROOM	365,410	365,410	0	0	0	2.00
3.00	91.00	EMERGENCY	937,080	0	937,080	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,872,318	367,762	1,504,556		0	200.00

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

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,352		1.00
2.00	50.00	OPERATING ROOM	0	0	0	365,410		2.00
3.00	91.00	EMERGENCY	0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	367,762		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/27/2024 3:24 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	CASHIERING/ACCOUNTS RECEIVABLE	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	59,749	59,749				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	499,017		499,017			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,041,470	481	4,017	1,045,968		4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	301,873	789	6,593	8,640	317,895	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	3,832,079	5,138	42,913	37,220	0	5.02
7.00	00700	OPERATION OF PLANT	1,512,341	18,999	158,668	24,322	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	242,005	1,057	8,831	286	0	8.00
9.00	00900	HOUSEKEEPING	266,046	840	7,019	35,902	0	9.00
10.00	01000	DIETARY	521,837	3,328	27,797	0	0	10.00
11.00	01100	CAFETERIA	-24,180	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	558,171	532	4,443	62,760	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	182,993	1,272	10,624	18,911	0	14.00
15.00	01500	PHARMACY	497,175	780	6,515	43,910	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,090	667	5,574	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,048,367	4,261	35,585	223,128	25,257	30.00
46.00	04600	OTHER LONG TERM CARE	521,597	2,130	17,790	72,803	1,431	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	399,151	2,482	20,729	43,768	15,455	50.00
51.00	05100	RECOVERY ROOM	61,632	0	0	9,434	2,845	51.00
53.00	05300	ANESTHESIOLOGY	216,469	0	0	0	1,470	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	962,749	3,517	29,374	93,242	108,203	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	983,308	1,222	10,208	56,554	45,935	60.00
65.00	06500	RESPIRATORY THERAPY	54,768	459	3,835	7,782	2,249	65.00
66.00	06600	PHYSICAL THERAPY	207,582	4,223	35,267	32,072	15,462	66.00
67.00	06700	OCCUPATIONAL THERAPY	310,455	324	2,709	50,415	5,879	67.00
68.00	06800	SPEECH PATHOLOGY	74,520	155	1,293	11,955	1,535	68.00
69.00	06900	ELECTROCARDIOLOGY	141,728	434	3,625	15,750	6,184	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	134,883	0	0	0	4,179	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,478	0	0	0	315	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	327,703	0	0	0	22,588	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	319,911	717	5,990	0	2,739	76.01
76.03	03950	WOUND CARE	5,787	389	3,252	350	94	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	570,209	2,037	17,011	49,710	4,580	88.00
91.00	09100	EMERGENCY	1,980,277	2,951	24,643	147,054	51,495	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,838,240	59,184	494,305	1,045,968	317,895	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	323	2,694	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	32,296	242	2,018	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,870,536	59,749	499,017	1,045,968	317,895	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/27/2024 3:24 pm

		Cost Center Description	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	3,917,350	3,917,350				5.02
7.00	00700	OPERATION OF PLANT	1,714,330	448,385	2,162,715			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	252,179	65,958	66,590	384,727		8.00
9.00	00900	HOUSEKEEPING	309,807	81,030	52,925	14,177	457,939	9.00
10.00	01000	DIETARY	552,962	144,628	209,594	2,509	46,976	10.00
11.00	01100	CAFETERIA	-24,180	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	625,906	163,706	33,498	0	7,508	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	213,800	55,920	80,107	0	17,954	14.00
15.00	01500	PHARMACY	548,380	143,429	49,121	0	11,009	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,331	3,487	42,030	0	9,420	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,336,598	611,145	268,319	117,750	60,140	30.00
46.00	04600	OTHER LONG TERM CARE	615,751	161,050	134,140	101,598	30,065	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	481,585	125,959	156,300	20,476	35,031	50.00
51.00	05100	RECOVERY ROOM	73,911	19,331	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	217,939	57,002	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,197,085	313,099	221,486	26,287	49,641	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,097,227	286,981	76,968	0	17,251	60.00
65.00	06500	RESPIRATORY THERAPY	69,093	18,071	28,918	0	6,481	65.00
66.00	06600	PHYSICAL THERAPY	294,606	77,054	265,917	26,287	59,599	66.00
67.00	06700	OCCUPATIONAL THERAPY	369,782	96,717	20,424	0	4,578	67.00
68.00	06800	SPEECH PATHOLOGY	89,458	23,398	9,750	0	2,185	68.00
69.00	06900	ELECTROCARDIOLOGY	167,721	43,868	27,330	0	6,125	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	139,062	36,372	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,793	5,177	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	350,291	91,619	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	329,357	86,144	45,169	0	10,124	76.01
76.03	03950	WOUND CARE	9,872	2,582	24,523	0	5,496	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	643,547	168,320	128,268	4,409	28,748	88.00
91.00	09100	EMERGENCY	2,206,420	577,091	185,809	71,234	41,645	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,832,963	3,907,523	2,127,186	384,727	449,976	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	3,017	789	20,313	0	4,553	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	34,556	9,038	15,216	0	3,410	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,870,536	3,917,350	2,162,715	384,727	457,939	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/27/2024 3:24 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	956,669					10.00
11.00	01100	CAFETERIA	318,912	294,732				11.00
13.00	01300	NURSING ADMINISTRATION	0	18,320	848,938			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,378	0	376,159		14.00
15.00	01500	PHARMACY	0	9,104	0	32,054	793,097	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	561	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	465,112	61,940	423,846	48,704	0	30.00
46.00	04600	OTHER LONG TERM CARE	135,518	33,455	0	2,565	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	16,756	101,058	50,685	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,297	0	51.00
53.00	05300	ANESTHESIOLOGY	0	168	0	3,642	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	29,546	0	11,041	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	22,508	0	41,135	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,239	14,783	2,051	0	65.00
66.00	06600	PHYSICAL THERAPY	0	14,131	0	421	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,176	0	733	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,513	0	975	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,636	29,918	683	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	104,163	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,316	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	793,097	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	59	0	76.01
76.03	03950	WOUND CARE	0	335	0	2,728	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	15,750	0	7,408	0	88.00
91.00	09100	EMERGENCY	8,045	41,777	279,333	43,938	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	927,587	294,732	848,938	376,159	793,097	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
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	29,082	0	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	956,669	294,732	848,938	376,159	793,097	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/27/2024 3:24 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	68,829					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,467	4,399,021	0	4,399,021		30.00
46.00	04600	OTHER LONG TERM CARE	310	1,214,452	0	1,214,452		46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,346	991,196	0	991,196		50.00
51.00	05100	RECOVERY ROOM	616	97,155	0	97,155		51.00
53.00	05300	ANESTHESIOLOGY	318	279,069	0	279,069		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,438	1,871,623	0	1,871,623		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	9,943	1,552,013	0	1,552,013		60.00
65.00	06500	RESPIRATORY THERAPY	487	143,123	0	143,123		65.00
66.00	06600	PHYSICAL THERAPY	3,347	741,362	0	741,362		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,273	505,683	0	505,683		67.00
68.00	06800	SPEECH PATHOLOGY	332	128,611	0	128,611		68.00
69.00	06900	ELECTROCARDIOLOGY	1,339	281,620	0	281,620		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	905	280,502	0	280,502		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	68	44,354	0	44,354		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,889	1,239,896	0	1,239,896		73.00
76.00	03610	SLEEP LAB	0	0	0	0		76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	593	471,446	0	471,446		76.01
76.03	03950	WOUND CARE	20	45,556	0	45,556		76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	991	997,441	0	997,441		88.00
91.00	09100	EMERGENCY	11,147	3,466,439	0	3,466,439		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	68,829	18,750,562	0	18,750,562		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	28,672	0	28,672		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	62,220	0	62,220		194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	29,082	0	29,082		194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0		194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0		194.04
194.05	07955	VACANT SPACE	0	0	0	0		194.05
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	68,829	18,870,536	0	18,870,536		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/27/2024 3:24 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	481	4,017	4,498	4,498	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	789	6,593	7,382	37	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	5,138	42,913	48,051	160	5.02
7.00	00700	OPERATION OF PLANT	0	18,999	158,668	177,667	105	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,057	8,831	9,888	1	8.00
9.00	00900	HOUSEKEEPING	0	840	7,019	7,859	154	9.00
10.00	01000	DIETARY	0	3,328	27,797	31,125	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	532	4,443	4,975	270	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,272	10,624	11,896	81	14.00
15.00	01500	PHARMACY	0	780	6,515	7,295	189	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	667	5,574	6,241	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,261	35,585	39,846	960	30.00
46.00	04600	OTHER LONG TERM CARE	0	2,130	17,790	19,920	313	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,482	20,729	23,211	188	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	41	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,517	29,374	32,891	401	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,222	10,208	11,430	243	60.00
65.00	06500	RESPIRATORY THERAPY	0	459	3,835	4,294	33	65.00
66.00	06600	PHYSICAL THERAPY	0	4,223	35,267	39,490	138	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	324	2,709	3,033	217	67.00
68.00	06800	SPEECH PATHOLOGY	0	155	1,293	1,448	51	68.00
69.00	06900	ELECTROCARDIOLOGY	0	434	3,625	4,059	68	69.00
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	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	717	5,990	6,707	0	76.01
76.03	03950	WOUND CARE	0	389	3,252	3,641	2	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,037	17,011	19,048	214	88.00
91.00	09100	EMERGENCY	0	2,951	24,643	27,594	632	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	59,184	494,305	553,489	4,498	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	323	2,694	3,017	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	242	2,018	2,260	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	59,749	499,017	558,766	4,498	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/27/2024 3:24 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	7,419					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	48,211				5.02
7.00	00700	OPERATION OF PLANT	0	5,518	183,290			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	812	5,643	16,344		8.00
9.00	00900	HOUSEKEEPING	0	997	4,485	602	14,097	9.00
10.00	01000	DIETARY	0	1,780	17,763	107	1,446	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,015	2,839	0	231	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	688	6,789	0	553	14.00
15.00	01500	PHARMACY	0	1,765	4,163	0	339	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	43	3,562	0	290	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	587	7,521	22,742	5,002	1,851	30.00
46.00	04600	OTHER LONG TERM CARE	33	1,982	11,368	4,316	925	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	359	1,550	13,246	870	1,078	50.00
51.00	05100	RECOVERY ROOM	66	238	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	34	702	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,546	3,853	18,771	1,117	1,528	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,068	3,532	6,523	0	531	60.00
65.00	06500	RESPIRATORY THERAPY	52	222	2,451	0	200	65.00
66.00	06600	PHYSICAL THERAPY	359	948	22,536	1,117	1,835	66.00
67.00	06700	OCCUPATIONAL THERAPY	137	1,190	1,731	0	141	67.00
68.00	06800	SPEECH PATHOLOGY	36	288	826	0	67	68.00
69.00	06900	ELECTROCARDIOLOGY	144	540	2,316	0	189	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	97	448	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7	64	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	525	1,128	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	64	1,060	3,828	0	312	76.01
76.03	03950	WOUND CARE	2	32	2,078	0	169	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	106	2,072	10,871	187	885	88.00
91.00	09100	EMERGENCY	1,197	7,102	15,747	3,026	1,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,419	48,090	180,278	16,344	13,852	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	10	1,722	0	140	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	111	1,290	0	105	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,419	48,211	183,290	16,344	14,097	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/27/2024 3:24 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	52,221					10.00
11.00	01100	CAFETERIA	17,408	16,088				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,000	11,330			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	457	0	20,464		14.00
15.00	01500	PHARMACY	0	497	0	1,744	15,992	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	31	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,390	3,381	5,657	2,650	0	30.00
46.00	04600	OTHER LONG TERM CARE	7,397	1,826	0	140	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	915	1,349	2,757	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	179	0	51.00
53.00	05300	ANESTHESIOLOGY	0	9	0	198	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,613	0	601	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,229	0	2,238	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	177	197	112	0	65.00
66.00	06600	PHYSICAL THERAPY	0	771	0	23	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	665	0	40	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	137	0	53	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	253	399	37	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,666	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,051	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	15,992	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	3	0	76.01
76.03	03950	WOUND CARE	0	18	0	148	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	860	0	403	0	88.00
91.00	09100	EMERGENCY	439	2,280	3,728	2,390	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,634	16,088	11,330	20,464	15,992	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
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	1,587	0	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	1,320	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	52,221	17,408	11,330	20,464	15,992	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/27/2024 3:24 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,167					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	811	116,398	0	116,398		30.00
46.00	04600	OTHER LONG TERM CARE	46	48,266	0	48,266		46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	496	46,019	0	46,019		50.00
51.00	05100	RECOVERY ROOM	91	615	0	615		51.00
53.00	05300	ANESTHESIOLOGY	47	990	0	990		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,438	66,759	0	66,759		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	1,474	28,268	0	28,268		60.00
65.00	06500	RESPIRATORY THERAPY	72	7,810	0	7,810		65.00
66.00	06600	PHYSICAL THERAPY	496	67,713	0	67,713		66.00
67.00	06700	OCCUPATIONAL THERAPY	189	7,343	0	7,343		67.00
68.00	06800	SPEECH PATHOLOGY	49	2,955	0	2,955		68.00
69.00	06900	ELECTROCARDIOLOGY	198	8,203	0	8,203		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	134	6,345	0	6,345		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10	1,132	0	1,132		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	725	18,370	0	18,370		73.00
76.00	03610	SLEEP LAB	0	0	0	0		76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	88	12,062	0	12,062		76.01
76.03	03950	WOUND CARE	3	6,093	0	6,093		76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	147	34,793	0	34,793		88.00
91.00	09100	EMERGENCY	1,653	67,070	0	67,070		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,167	547,204	0	547,204		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	4,889	0	4,889		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	3,766	0	3,766		194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	1,587	0	1,587		194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0		194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0		194.04
194.05	07955	VACANT SPACE	0	0	0	0		194.05
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	1,320	0	1,320		201.00
202.00		TOTAL (sum lines 118 through 201)	10,167	558,766	0	558,766		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/27/2024 3:24 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	
			1.00	2.00	4.00	5.01	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	101,878					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		101,878				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	820	820	5,987,035			4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,346	1,346	49,457	70,357,390		5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	8,761	8,761	213,042	0	-3,917,350	5.02
7.00	00700	OPERATION OF PLANT	32,393	32,393	139,219	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,803	1,803	1,636	0	0	8.00
9.00	00900	HOUSEKEEPING	1,433	1,433	205,500	0	0	9.00
10.00	01000	DIETARY	5,675	5,675	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	24,180	11.00
13.00	01300	NURSING ADMINISTRATION	907	907	359,230	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,169	2,169	108,242	0	0	14.00
15.00	01500	PHARMACY	1,330	1,330	251,339	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,138	1,138	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,265	7,265	1,277,180	5,590,319	0	30.00
46.00	04600	OTHER LONG TERM CARE	3,632	3,632	416,715	316,840	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,232	4,232	250,524	3,420,860	0	50.00
51.00	05100	RECOVERY ROOM	0	0	53,997	629,595	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	325,407	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,997	5,997	533,709	23,944,741	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,084	2,084	323,709	10,167,004	0	60.00
65.00	06500	RESPIRATORY THERAPY	783	783	44,546	497,853	0	65.00
66.00	06600	PHYSICAL THERAPY	7,200	7,200	183,575	3,422,333	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	553	553	288,573	1,301,279	0	67.00
68.00	06800	SPEECH PATHOLOGY	264	264	68,429	339,785	0	68.00
69.00	06900	ELECTROCARDIOLOGY	740	740	90,152	1,368,703	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	924,982	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	69,762	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,999,460	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,223	1,223	0	606,159	0	76.01
76.03	03950	WOUND CARE	664	664	2,004	20,896	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,473	3,473	284,537	1,013,757	0	88.00
91.00	09100	EMERGENCY	5,031	5,031	841,720	11,397,655	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100,916	100,916	5,987,035	70,357,390	-3,893,170	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	550	550	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	412	412	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	59,749	499,017	1,045,968	317,895		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.586476	4.898182	0.174706	0.004518		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			4,498	7,419		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000751	0.000105		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: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/27/2024 3:24 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LBS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.02	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	14,977,366					5.02
7.00	00700	OPERATION OF PLANT	1,714,330	58,558				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	252,179	1,803	41,711			8.00
9.00	00900	HOUSEKEEPING	309,807	1,433	1,537	55,322		9.00
10.00	01000	DIETARY	552,962	5,675	272	5,675	14,507	10.00
11.00	01100	CAFETERIA	0	0	0	0	4,836	11.00
13.00	01300	NURSING ADMINISTRATION	625,906	907	0	907	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	213,800	2,169	0	2,169	0	14.00
15.00	01500	PHARMACY	548,380	1,330	0	1,330	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,331	1,138	0	1,138	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,336,598	7,265	12,766	7,265	7,053	30.00
46.00	04600	OTHER LONG TERM CARE	615,751	3,632	11,015	3,632	2,055	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	481,585	4,232	2,220	4,232	0	50.00
51.00	05100	RECOVERY ROOM	73,911	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	217,939	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,197,085	5,997	2,850	5,997	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,097,227	2,084	0	2,084	0	60.00
65.00	06500	RESPIRATORY THERAPY	69,093	783	0	783	0	65.00
66.00	06600	PHYSICAL THERAPY	294,606	7,200	2,850	7,200	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	369,782	553	0	553	0	67.00
68.00	06800	SPEECH PATHOLOGY	89,458	264	0	264	0	68.00
69.00	06900	ELECTROCARDIOLOGY	167,721	740	0	740	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	139,062	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,793	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	350,291	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	329,357	1,223	0	1,223	0	76.01
76.03	03950	WOUND CARE	9,872	664	0	664	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	643,547	3,473	478	3,473	0	88.00
91.00	09100	EMERGENCY	2,206,420	5,031	7,723	5,031	122	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,939,793	57,596	41,711	54,360	14,066	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	3,017	550	0	550	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	34,556	412	0	412	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	0	441	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,917,350	2,162,715	384,727	457,939	956,669	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.261551	36.932870	9.223634	8.277701	65.945337	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	48,211	183,290	16,344	14,097	52,221	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003219	3.130059	0.391839	0.254817	3.599710	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: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/27/2024 3:24 pm

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	5,277					11.00
13.00	01300	NURSING ADMINISTRATION	328	2,558,119				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	150	0	379,323			14.00
15.00	01500	PHARMACY	163	0	32,324	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	566	0	70,357,390	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,109	1,277,180	49,114	0	5,590,319	30.00
46.00	04600	OTHER LONG TERM CARE	599	0	2,587	0	316,840	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	300	304,521	51,111	0	3,420,860	50.00
51.00	05100	RECOVERY ROOM	0	0	3,325	0	629,595	51.00
53.00	05300	ANESTHESIOLOGY	3	0	3,673	0	325,407	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	529	0	11,134	0	23,944,741	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	403	0	41,481	0	10,167,004	60.00
65.00	06500	RESPIRATORY THERAPY	58	44,546	2,068	0	497,853	65.00
66.00	06600	PHYSICAL THERAPY	253	0	425	0	3,422,333	66.00
67.00	06700	OCCUPATIONAL THERAPY	218	0	739	0	1,301,279	67.00
68.00	06800	SPEECH PATHOLOGY	45	0	983	0	339,785	68.00
69.00	06900	ELECTROCARDIOLOGY	83	90,152	689	0	1,368,703	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	105,037	0	924,982	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	19,478	0	69,762	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	4,999,460	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	60	0	606,159	76.01
76.03	03950	WOUND CARE	6	0	2,751	0	20,896	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	282	0	7,470	0	1,013,757	88.00
91.00	09100	EMERGENCY	748	841,720	44,308	0	11,397,655	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,277	2,558,119	379,323	100	70,357,390	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
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	294,732	848,938	376,159	793,097	68,829	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	55.852189	0.331860	0.991659	7,930.970000	0.000978	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	17,408	11,330	20,464	15,992	10,167	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.048702	0.004429	0.053949	159.920000	0.000145	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 3:24 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	4,399,021		4,399,021	0	0	30.00
46.00	04600	OTHER LONG TERM CARE	1,214,452		1,214,452	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	991,196		991,196	0	0	50.00
51.00	05100	RECOVERY ROOM	97,155		97,155	0	0	51.00
53.00	05300	ANESTHESIOLOGY	279,069		279,069	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,871,623		1,871,623	0	0	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	1,552,013		1,552,013	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	143,123	0	143,123	0	0	65.00
66.00	06600	PHYSICAL THERAPY	741,362	0	741,362	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	505,683	0	505,683	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	128,611	0	128,611	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	281,620		281,620	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	280,502		280,502	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,354		44,354	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,239,896		1,239,896	0	0	73.00
76.00	03610	SLEEP LAB	0		0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	471,446		471,446	0	0	76.01
76.03	03950	WOUND CARE	45,556		45,556	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	997,441		997,441	0	0	88.00
91.00	09100	EMERGENCY	3,466,439		3,466,439	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	690,037		690,037		0	92.00
200.00		Subtotal (see instructions)	19,440,599	0	19,440,599	0	0	200.00
201.00		Less Observation Beds	690,037		690,037		0	201.00
202.00		Total (see instructions)	18,750,562	0	18,750,562	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 3:24 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	5,128,955		5,128,955			30.00
46.00	04600	OTHER LONG TERM CARE	316,840		316,840			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	343,659	3,077,201	3,420,860	0.289751	0.000000	50.00
51.00	05100	RECOVERY ROOM	53,458	576,137	629,595	0.154313	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	36,036	289,371	325,407	0.857600	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,128,990	22,815,751	23,944,741	0.078164	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	1,560,928	8,606,076	10,167,004	0.152652	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	418,785	79,068	497,853	0.287480	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	625,613	2,796,720	3,422,333	0.216625	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	503,981	797,298	1,301,279	0.388605	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	199,828	139,957	339,785	0.378507	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	240,293	1,128,410	1,368,703	0.205757	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	797,604	127,378	924,982	0.303251	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43	69,719	69,762	0.635790	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,128,716	2,870,744	4,999,460	0.248006	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	606,159	606,159	0.777760	0.000000	76.01
76.03	03950	WOUND CARE	0	20,896	20,896	2.180130	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,013,757	1,013,757			88.00
91.00	09100	EMERGENCY	292,219	11,105,436	11,397,655	0.304136	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	29,241	432,123	461,364	1.495646	0.000000	92.00
200.00		Subtotal (see instructions)	13,805,189	56,552,201	70,357,390			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,805,189	56,552,201	70,357,390			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 3:24 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
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	03610	SLEEP LAB	0.000000		76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.01
76.03	03950	WOUND CARE	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
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: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 3:24 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,399,021		4,399,021	0	4,399,021	30.00
46.00	04600	OTHER LONG TERM CARE	1,214,452		1,214,452	0	1,214,452	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	991,196		991,196	0	991,196	50.00
51.00	05100	RECOVERY ROOM	97,155		97,155	0	97,155	51.00
53.00	05300	ANESTHESIOLOGY	279,069		279,069	0	279,069	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,871,623		1,871,623	0	1,871,623	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	1,552,013		1,552,013	0	1,552,013	60.00
65.00	06500	RESPIRATORY THERAPY	143,123	0	143,123	0	143,123	65.00
66.00	06600	PHYSICAL THERAPY	741,362	0	741,362	0	741,362	66.00
67.00	06700	OCCUPATIONAL THERAPY	505,683	0	505,683	0	505,683	67.00
68.00	06800	SPEECH PATHOLOGY	128,611	0	128,611	0	128,611	68.00
69.00	06900	ELECTROCARDIOLOGY	281,620		281,620	0	281,620	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	280,502		280,502	0	280,502	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,354		44,354	0	44,354	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,239,896		1,239,896	0	1,239,896	73.00
76.00	03610	SLEEP LAB	0		0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	471,446		471,446	0	471,446	76.01
76.03	03950	WOUND CARE	45,556		45,556	0	45,556	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	997,441		997,441	0	997,441	88.00
91.00	09100	EMERGENCY	3,466,439		3,466,439	0	3,466,439	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	690,037		690,037		690,037	92.00
200.00		Subtotal (see instructions)	19,440,599	0	19,440,599	0	19,440,599	200.00
201.00		Less Observation Beds	690,037		690,037		690,037	201.00
202.00		Total (see instructions)	18,750,562	0	18,750,562	0	18,750,562	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 3:24 pm

Title XIX | Hospital | PPS

		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	5,128,955		5,128,955			30.00
46.00	04600	OTHER LONG TERM CARE	316,840		316,840			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	343,659	3,077,201	3,420,860	0.289751	0.000000	50.00
51.00	05100	RECOVERY ROOM	53,458	576,137	629,595	0.154313	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	36,036	289,371	325,407	0.857600	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,128,990	22,815,751	23,944,741	0.078164	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	1,560,928	8,606,076	10,167,004	0.152652	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	418,785	79,068	497,853	0.287480	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	625,613	2,796,720	3,422,333	0.216625	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	503,981	797,298	1,301,279	0.388605	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	199,828	139,957	339,785	0.378507	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	240,293	1,128,410	1,368,703	0.205757	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	797,604	127,378	924,982	0.303251	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43	69,719	69,762	0.635790	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,128,716	2,870,744	4,999,460	0.248006	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	606,159	606,159	0.777760	0.000000	76.01
76.03	03950	WOUND CARE	0	20,896	20,896	2.180130	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,013,757	1,013,757	0.983905	0.000000	88.00
91.00	09100	EMERGENCY	292,219	11,105,436	11,397,655	0.304136	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	29,241	432,123	461,364	1.495646	0.000000	92.00
200.00		Subtotal (see instructions)	13,805,189	56,552,201	70,357,390			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,805,189	56,552,201	70,357,390			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 3:24 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.289751		50.00
51.00	05100	RECOVERY ROOM	0.154313		51.00
53.00	05300	ANESTHESIOLOGY	0.857600		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.078164		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.152652		60.00
65.00	06500	RESPIRATORY THERAPY	0.287480		65.00
66.00	06600	PHYSICAL THERAPY	0.216625		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388605		67.00
68.00	06800	SPEECH PATHOLOGY	0.378507		68.00
69.00	06900	ELECTROCARDIOLOGY	0.205757		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.303251		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.635790		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.248006		73.00
76.00	03610	SLEEP LAB	0.000000		76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.777760		76.01
76.03	03950	WOUND CARE	2.180130		76.03
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.983905		88.00
91.00	09100	EMERGENCY	0.304136		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.495646		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part II Date/Time Prepared: 2/27/2024 3:24 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	991,196	46,019	945,177	0	0	50.00
51.00	05100	RECOVERY ROOM	97,155	615	96,540	0	0	51.00
53.00	05300	ANESTHESIOLOGY	279,069	990	278,079	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,871,623	66,759	1,804,864	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,552,013	28,268	1,523,745	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	143,123	7,810	135,313	0	0	65.00
66.00	06600	PHYSICAL THERAPY	741,362	67,713	673,649	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	505,683	7,343	498,340	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	128,611	2,955	125,656	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	281,620	8,203	273,417	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	280,502	6,345	274,157	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,354	1,132	43,222	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,239,896	18,370	1,221,526	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	471,446	12,062	459,384	0	0	76.01
76.03	03950	WOUND CARE	45,556	6,093	39,463	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	997,441	34,793	962,648	0	0	88.00
91.00	09100	EMERGENCY	3,466,439	67,070	3,399,369	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	690,037	18,258	671,779	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	13,827,126	400,798	13,426,328	0	0	200.00
201.00		Less Observation Beds	690,037	18,258	671,779	0	0	201.00
202.00		Total (line 200 minus line 201)	13,137,089	382,540	12,754,549	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part II Date/Time Prepared: 2/27/2024 3:24 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	991,196	3,420,860	0.289751		50.00
51.00	05100	RECOVERY ROOM	97,155	629,595	0.154313		51.00
53.00	05300	ANESTHESIOLOGY	279,069	325,407	0.857600		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,871,623	23,944,741	0.078164		54.00
54.01	05401	ULTRASOUND	0	0	0.000000		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MRI	0	0	0.000000		58.00
60.00	06000	LABORATORY	1,552,013	10,167,004	0.152652		60.00
65.00	06500	RESPIRATORY THERAPY	143,123	497,853	0.287480		65.00
66.00	06600	PHYSICAL THERAPY	741,362	3,422,333	0.216625		66.00
67.00	06700	OCCUPATIONAL THERAPY	505,683	1,301,279	0.388605		67.00
68.00	06800	SPEECH PATHOLOGY	128,611	339,785	0.378507		68.00
69.00	06900	ELECTROCARDIOLOGY	281,620	1,368,703	0.205757		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	280,502	924,982	0.303251		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,354	69,762	0.635790		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,239,896	4,999,460	0.248006		73.00
76.00	03610	SLEEP LAB	0	0	0.000000		76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	471,446	606,159	0.777760		76.01
76.03	03950	WOUND CARE	45,556	20,896	2.180130		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	997,441	1,013,757	0.983905		88.00
91.00	09100	EMERGENCY	3,466,439	11,397,655	0.304136		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	690,037	461,364	1.495646		92.00
200.00		Subtotal (sum of lines 50 thru 199)	13,827,126	64,911,595			200.00
201.00		Less Observation Beds	690,037	0			201.00
202.00		Total (line 200 minus line 201)	13,137,089	64,911,595			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/27/2024 3:24 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	46,019	3,420,860	0.013452	96,183	1,294	50.00
51.00	05100	RECOVERY ROOM	615	629,595	0.000977	10,948	11	51.00
53.00	05300	ANESTHESIOLOGY	990	325,407	0.003042	6,293	19	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,759	23,944,741	0.002788	301,991	842	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	28,268	10,167,004	0.002780	479,685	1,334	60.00
65.00	06500	RESPIRATORY THERAPY	7,810	497,853	0.015687	162,488	2,549	65.00
66.00	06600	PHYSICAL THERAPY	67,713	3,422,333	0.019786	45,158	893	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,343	1,301,279	0.005643	35,581	201	67.00
68.00	06800	SPEECH PATHOLOGY	2,955	339,785	0.008697	36,761	320	68.00
69.00	06900	ELECTROCARDIOLOGY	8,203	1,368,703	0.005993	120,536	722	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,345	924,982	0.006860	339,688	2,330	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,132	69,762	0.016227	43	1	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,370	4,999,460	0.003674	797,410	2,930	73.00
76.00	03610	SLEEP LAB	0	0	0.000000	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	12,062	606,159	0.019899	0	0	76.01
76.03	03950	WOUND CARE	6,093	20,896	0.291587	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	34,793	1,013,757	0.034321	0	0	88.00
91.00	09100	EMERGENCY	67,070	11,397,655	0.005885	50,967	300	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	18,258	461,364	0.039574	3,747	148	92.00
200.00		Total (lines 50 through 199)	400,798	64,911,595		2,487,479	13,894	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/27/2024 3:24 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/27/2024 3:24 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	3,420,860	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	629,595	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	325,407	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,944,741	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	10,167,004	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	497,853	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,422,333	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,301,279	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	339,785	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,368,703	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	924,982	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	69,762	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,999,460	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	606,159	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	20,896	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,013,757	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	11,397,655	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	461,364	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	64,911,595		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/27/2024 3:24 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	96,183	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	10,948	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	6,293	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	301,991	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	479,685	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	162,488	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	45,158	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	35,581	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	36,761	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	120,536	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	339,688	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	43	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	797,410	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	50,967	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	3,747	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,487,479	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/27/2024 3:24 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	0.289751	0	539,510	0	0	50.00
51.00	05100	RECOVERY ROOM	0.154313	0	90,859	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.857600	0	42,502	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.078164	0	5,305,545	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.152652	0	2,182,318	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.287480	0	77,170	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.216625	0	767,205	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388605	0	219,679	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.378507	0	51,148	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.205757	0	233,735	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.303251	0	36,643	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.635790	0	33,096	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.248006	0	1,100,721	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.777760	0	586,634	0	0	76.01
76.03	03950	WOUND CARE	2.180130	0	5,135	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	0.304136	0	2,654,311	214	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.495646	0	179,492	0	0	92.00
200.00		Subtotal (see instructions)		0	14,105,703	214	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	14,105,703	214	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/27/2024 3:24 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	156,324	0		50.00
51.00	05100	RECOVERY ROOM	14,021	0		51.00
53.00	05300	ANESTHESIOLOGY	36,450	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	414,703	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	333,135	0		60.00
65.00	06500	RESPIRATORY THERAPY	22,185	0		65.00
66.00	06600	PHYSICAL THERAPY	166,196	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	85,368	0		67.00
68.00	06800	SPEECH PATHOLOGY	19,360	0		68.00
69.00	06900	ELECTROCARDIOLOGY	48,093	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,112	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,042	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	272,985	0		73.00
76.00	03610	SLEEP LAB	0	0		76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	456,260	0		76.01
76.03	03950	WOUND CARE	11,195	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	807,272	65		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	268,456	0		92.00
200.00		Subtotal (see instructions)	3,144,157	65		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,144,157	65		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part I Date/Time Prepared: 2/27/2024 3:24 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	116,398	41,316	75,082	1,246	60.26	30.00
200.00	Total (lines 30 through 199)	116,398		75,082	1,246		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	4	241	30.00
200.00	Total (lines 30 through 199)	4	241	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/27/2024 3:24 pm

Title XIX | Hospital | PPS

		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	46,019	3,420,860	0.013452	24,381	328	50.00
51.00	05100	RECOVERY ROOM	615	629,595	0.000977	3,726	4	51.00
53.00	05300	ANESTHESIOLOGY	990	325,407	0.003042	2,188	7	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,759	23,944,741	0.002788	672	2	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	28,268	10,167,004	0.002780	3,650	10	60.00
65.00	06500	RESPIRATORY THERAPY	7,810	497,853	0.015687	0	0	65.00
66.00	06600	PHYSICAL THERAPY	67,713	3,422,333	0.019786	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,343	1,301,279	0.005643	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,955	339,785	0.008697	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,203	1,368,703	0.005993	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,345	924,982	0.006860	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,132	69,762	0.016227	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,370	4,999,460	0.003674	12,889	47	73.00
76.00	03610	SLEEP LAB	0	0	0.000000	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	12,062	606,159	0.019899	0	0	76.01
76.03	03950	WOUND CARE	6,093	20,896	0.291587	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	34,793	1,013,757	0.034321	0	0	88.00
91.00	09100	EMERGENCY	67,070	11,397,655	0.005885	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	18,258	461,364	0.039574	0	0	92.00
200.00		Total (lines 50 through 199)	400,798	64,911,595		47,506	398	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part III Date/Time Prepared: 2/27/2024 3:24 pm

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,246	0.00	4	30.00
200.00		Total (lines 30 through 199)		0	1,246		4	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/27/2024 3:24 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/27/2024 3:24 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	3,420,860	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	629,595	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	325,407	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,944,741	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	10,167,004	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	497,853	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,422,333	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,301,279	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	339,785	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,368,703	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	924,982	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	69,762	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,999,460	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	606,159	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	20,896	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,013,757	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	11,397,655	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	461,364	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	64,911,595		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/27/2024 3:24 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	24,381	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	3,726	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,188	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	672	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	3,650	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	12,889	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		47,506	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 3:24 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)	2,394	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,246	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)	943	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	639	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	509	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	480	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)	639	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	208.70	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,399,021	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)	106,228	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,561,448	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,837,573	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)	2,837,573	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)	2,277.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,093,123	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)	1,093,123	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 3:24 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)	562,726	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)	1,655,849	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	1,455,220	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	1,455,220	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)	303	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,277.35	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1342	Period: From 01/14/2023 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/27/2024 3:24 pm
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	690,037	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	116,398	4,399,021	0.026460	690,037	18,258	90.00
91.00	Nursing Program cost	0	4,399,021	0.000000	690,037	0	91.00
92.00	Allied health cost	0	4,399,021	0.000000	690,037	0	92.00
93.00	All other Medical Education	0	4,399,021	0.000000	690,037	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 3:24 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,394	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,246	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)	943	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	639	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	509	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	4	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	208.70	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,399,021	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)	106,228	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,561,448	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,837,573	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)	2,837,573	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)	2,277.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	9,109	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)	9,109	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 3:24 pm

Title XIX | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	13,322	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)	22,431	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)	241	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	398	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	639	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	21,792	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)	303	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,277.35	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 3:24 pm

Title XIX | Hospital | PPS

	Cost Center Description						
						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					690,037	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	116,398	4,399,021	0.026460	690,037	18,258	90.00
91.00	Nursing Program cost	0	4,399,021	0.000000	690,037	0	91.00
92.00	Allied health cost	0	4,399,021	0.000000	690,037	0	92.00
93.00	All other Medical Education	0	4,399,021	0.000000	690,037	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/27/2024 3:24 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		1,101,202		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.289751	96,183	27,869	50.00
51.00	05100	RECOVERY ROOM	0.154313	10,948	1,689	51.00
53.00	05300	ANESTHESIOLOGY	0.857600	6,293	5,397	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.078164	301,991	23,605	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.152652	479,685	73,225	60.00
65.00	06500	RESPIRATORY THERAPY	0.287480	162,488	46,712	65.00
66.00	06600	PHYSICAL THERAPY	0.216625	45,158	9,782	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388605	35,581	13,827	67.00
68.00	06800	SPEECH PATHOLOGY	0.378507	36,761	13,914	68.00
69.00	06900	ELECTROCARDIOLOGY	0.205757	120,536	24,801	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.303251	339,688	103,011	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.635790	43	27	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.248006	797,410	197,762	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.777760	0	0	76.01
76.03	03950	WOUND CARE	2.180130	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.304136	50,967	15,501	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.495646	3,747	5,604	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,487,479	562,726	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)		2,487,479		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-3

Component CCN: 14-Z342 | Date/Time Prepared: 2/27/2024 3:24 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	0.289751	1,897	550	50.00
51.00	05100	RECOVERY ROOM	0.154313	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.857600	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.078164	55,971	4,375	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.152652	276,622	42,227	60.00
65.00	06500	RESPIRATORY THERAPY	0.287480	136,820	39,333	65.00
66.00	06600	PHYSICAL THERAPY	0.216625	288,645	62,528	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388605	235,767	91,620	67.00
68.00	06800	SPEECH PATHOLOGY	0.378507	89,265	33,787	68.00
69.00	06900	ELECTROCARDIOLOGY	0.205757	2,199	452	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.303251	264,031	80,068	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.635790	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.248006	363,761	90,215	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.777760	0	0	76.01
76.03	03950	WOUND CARE	2.180130	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.304136	699	213	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.495646	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,715,677	445,368	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)		1,715,677		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/27/2024 3:24 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		9,592		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.289751	24,381	7,064	50.00
51.00	05100	RECOVERY ROOM	0.154313	3,726	575	51.00
53.00	05300	ANESTHESIOLOGY	0.857600	2,188	1,876	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.078164	672	53	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.152652	3,650	557	60.00
65.00	06500	RESPIRATORY THERAPY	0.287480	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.216625	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388605	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.378507	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.205757	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.303251	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.635790	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.248006	12,889	3,197	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.777760	0	0	76.01
76.03	03950	WOUND CARE	2.180130	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.983905	0	0	88.00
91.00	09100	EMERGENCY	0.304136	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.495646	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		47,506	13,322	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)		47,506		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E Part B Date/Time Prepared: 2/27/2024 3:24 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,144,222	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)	3,144,222	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)	3,175,664	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)	15,145	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,343,459	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)	817,060	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)	817,060	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	817,060	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)	93,421	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	60,724	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	93,421	36.00
37.00	Subtotal (see instructions)	877,784	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)	877,784	40.00
40.01	Sequestration adjustment (see instructions)	17,556	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	1,309,013	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)	-448,785	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: 14-1342	Period: From 01/14/2023 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/27/2024 3:24 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: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E-1 Part I Date/Time Prepared: 2/27/2024 3:24 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		979,216		1,309,013	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		979,216		1,309,013	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		533,205		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		448,785	6.02
7.00	Total Medicare program liability (see instructions)		1,512,421		860,228	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: 14-1342 | Component CCN: 14-Z342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/27/2024 3:24 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		1,315,773		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,315,773		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		542,344		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,858,117		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: 14-1342	Period: From 01/14/2023 To 09/30/2023	Worksheet E-1 Part II Date/Time Prepared: 2/27/2024 3:24 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: 14-1342 | Component CCN: 14-Z342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E-2 | Date/Time Prepared: 2/27/2024 3:24 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)	1,469,772	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)	449,822	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	639	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)	1,919,594	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,919,594	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)	1,919,594	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	23,556	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,896,038	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)	1,896,038	0	19.00
19.01	Sequestration adjustment (see instructions)	37,921	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	1,315,773	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)	542,344	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: 14-1342	Period: From 01/14/2023 To 09/30/2023	Worksheet E-3 Part V Date/Time Prepared: 2/27/2024 3:24 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,655,849	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)	1,655,849	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,672,407	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)	1,672,407	19.00
20.00	Deductibles (exclude professional component)	126,400	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,546,007	22.00
23.00	Coinsurance	4,800	23.00
24.00	Subtotal (line 22 minus line 23)	1,541,207	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	3,200	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	2,080	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,200	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,543,287	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)	1,543,287	30.00
30.01	Sequestration adjustment (see instructions)	30,866	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	979,216	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)	533,205	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: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E-3 Part VII Date/Time Prepared: 2/27/2024 3:24 pm

Title XIX | Hospital | PPS

		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	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	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)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	9,592		8.00
9.00	Ancillary service charges	47,506	0	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)	57,098	0	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)	57,098	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	57,098	0	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)	0	0	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)	0	0	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)	0	0	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)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	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)	0	0	40.00
41.00	Interim payments	2,689	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-2,689	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: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet G | Date/Time Prepared: 2/27/2024 3:24 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	5,150,047	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	34,606,243	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-26,484,244	0	0	0	6.00
7.00	Inventory	513,154	0	0	0	7.00
8.00	Prepaid expenses	1,137,612	0	0	0	8.00
9.00	Other current assets	-30,914	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)	14,891,898	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	3,670,918	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	4,239,807	0	0	0	23.00
24.00	Accumulated depreciation	-499,017	0	0	0	24.00
25.00	Minor equipment depreciable	33,119	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,444,827	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	663,114	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	663,114	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	22,999,839	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,784,199	0	0	0	37.00
38.00	Salaries, wages, and fees payable	-1,048,200	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	296,932	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,032,931	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	10,258,804	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,258,804	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15,291,735	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	7,708,104				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	7,708,104	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	22,999,839	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet G-1 | Date/Time Prepared: 2/27/2024 3:24 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		7,708,104		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-415,287				2.00
3.00	Total (sum of line 1 and line 2)		7,292,817		0		3.00
4.00	NI DOUBLE COUNTED	415,287		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)		415,287		0		10.00
11.00	Subtotal (line 3 plus line 10)		7,708,104		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		7,708,104		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	NI DOUBLE COUNTED		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: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/27/2024 3:24 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,354,844		2,354,844	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,449,315		1,449,315	5.00
6.00	Swing bed - NF	1,259,249		1,259,249	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	316,840		316,840	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,380,248		5,380,248	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)	5,380,248		5,380,248	17.00
18.00	Ancillary services	8,067,175	44,498,555	52,565,730	18.00
19.00	Outpatient services	292,219	11,105,436	11,397,655	19.00
20.00	RURAL HEALTH CLINIC	0	1,013,757	1,013,757	20.00
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	PRO FEES	60,619	601,469	662,088	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	13,800,261	57,219,217	71,019,478	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,618,474		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)		20,618,474		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1342 | Period: From 01/14/2023 To 09/30/2023 | Worksheet G-3 | Date/Time Prepared: 2/27/2024 3:24 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	71,019,478	1.00
2.00	Less contractual allowances and discounts on patients' accounts	52,119,702	2.00
3.00	Net patient revenues (line 1 minus line 2)	18,899,776	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,618,474	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,718,698	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	950,001	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	24,180	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	574	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	OTHER OPERATING INCOME	328,656	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,303,411	25.00
26.00	Total (line 5 plus line 25)	-415,287	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)	-415,287	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1342
Component CCN: 14-3975

Period: From 01/14/2023 To 09/30/2023

Worksheet M-1
Date/Time Prepared: 2/27/2024 3:24 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	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	333,994	27,639	361,633	0	361,633	9.00
10.00	Subtotal (sum of lines 1 through 9)	333,994	27,639	361,633	0	361,633	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	19,321	19,321	0	19,321	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	19,321	19,321	0	19,321	14.00
15.00	Medical Supplies	0	8,796	8,796	0	8,796	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	8,796	8,796	0	8,796	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	333,994	55,756	389,750	0	389,750	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	804	804	0	804	29.00
30.00	Administrative Costs	0	22,531	22,531	-49,457	-26,926	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	23,335	23,335	-49,457	-26,122	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	333,994	79,091	413,085	-49,457	363,628	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1342 | Component CCN: 14-3975 | Period: From 01/14/2023 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/27/2024 3:24 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	83,653	83,653		1.00
2.00	Physician Assistant	85,864	85,864		2.00
3.00	Nurse Practitioner	37,064	37,064		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	361,633		9.00
10.00	Subtotal (sum of lines 1 through 9)	206,581	568,214		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	19,321		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	19,321		14.00
15.00	Medical Supplies	0	8,796		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	8,796		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	206,581	596,331		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	804		29.00
30.00	Administrative Costs	0	-26,926		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	-26,122		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	206,581	570,209		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1342 | Component CCN: 14-3975 | Period: From 01/14/2023 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/27/2024 3:24 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	0.28	1,139	4,200	1,176		1.00
2.00	Physician Assistant	0.65	1,860	2,100	1,365		2.00
3.00	Nurse Practitioner	0.25	1,992	2,100	525		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.18	4,991		3,066	4,991	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)	1.18	4,991			4,991	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)					596,331	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					596,331	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					-26,122	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					427,232	15.00
16.00	Total overhead (sum of lines 14 and 15)					401,110	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					401,110	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					401,110	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					997,441	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1342 Component CCN: 14-3975	Period: From 01/14/2023 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/27/2024 3:24 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)		997,441	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		331	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		997,110	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,991	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		4,991	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		199.78	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/14/2023 through 09/30/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	260.83	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	199.78	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	530	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	105,883	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	105,883	16.00
16.01	Total program charges (see instructions)(from contractor's records)		100,650	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	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.)		80,891	16.04
16.05	Total program cost (see instructions)	0	80,891	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,769	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		19,176	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		80,891	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		331	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		81,222	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		81,222	26.00
26.01	Sequestration adjustment (see instructions)		1,624	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		104,640	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)		-25,042	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: 14-1342 | Component CCN: 14-3975 | Period: From 01/14/2023 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/27/2024 3:24 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)	568,214	568,214	568,214	568,214	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000068	0.000068	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	39	39	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	100	20	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	139	59	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	596,331	596,331	596,331	596,331	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	401,110	401,110	401,110	401,110	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000233	0.000099	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	93	40	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	232	99	0	0	10.00
11.00	Total number of injections/infusions (from your records)	1	1	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	232.00	99.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	1	1	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)	232	99	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)		331	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)		331	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1342 Component CCN: 14-3975	Period: From 01/14/2023 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/27/2024 3:24 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		104,640	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		104,640	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		25,042	6.02
7.00	Total Medicare program liability (see instructions)		79,598	7.00

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