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: 14-0210	Period: From 04/01/2022 To 03/31/2023	Worksheet S Parts I-III Date/Time Prepared: 9/11/2023 9:16 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 9/11/2023 Time: 9:16 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR Of PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARRISBURG MEDICAL CENTER, INC. (14-0210) for the cost reporting period beginning 04/01/2022 and ending 03/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Warren Ladner		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	Warren Ladner			2
3	Signatory Title	SENIOR VP / 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	100,864	-64,717	0	0	1.00
2.00	SUBPROVIDER - IPF	0	-50,110	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		72,601		0	10.00
10.01	RURAL HEALTH CLINIC II	0		51,880		0	10.01
200.00	TOTAL	0	50,754	59,764	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 9/11/2023 9:16 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 100 DR WARREN TUTTLE DRIVE	PO Box:			1.00
2.00	City: HARRISBURG	State: IL	Zip Code: 62946	County: SALINE	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	HARRISBURG MEDICAL CENTER, INC.	140210	99914	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF	HARRISBURG MEDICAL CENTER, INC.	14S210	99914	4	06/19/1989	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	HARRISBURG MEDICAL CENTER, INC.	14U210	99914		11/03/1988	N	P	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	ELDORADO PRIMARY CARE	143473	99914		12/31/2001	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	HMC AT MARION	148590	99914		06/05/2018	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	04/01/2022	03/31/2023	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.	Y	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)	Y	Y		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: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 9/11/2023 9:16 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	27	0	0	0	216	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.	1		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.	04/01/2022	03/31/2023	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)	Y	Y	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)	Y	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.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 9/11/2023 9:16 am

		V	XVIII	XIX	
		1.00	2.00	3.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 9/11/2023 9:16 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 9/11/2023 9:16 am

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			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)	N	N	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)	N	N	0	76.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 9/11/2023 9:16 am

		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?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	58,641	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H124	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: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Name: NGS	Contractor's Number: 00131	141.00
142.00	Street: 1239 E. MAIN STREET	PO Box: POB 3988		142.00
143.00	City: CARBONDALE	State: IL	Zip Code: 62902-3988	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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 9/11/2023 9:16 am

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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	08/21/2023	Y	08/21/2023	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

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		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.	Y	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	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.	LUANNE	WARREN	41.00
42.00	Enter the employer/company name of the cost report preparer.	SOUTHERN ILLINOIS HEALTHCARE		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-457-5200 EXT 67202	LUANNE.WARREN@SIH.NET	43.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 9/11/2023 9:16 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	40	14,600	0.00	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)		40	14,600	0.00	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)		40	14,600	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	40.00	31	11,315		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		71				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: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 9/11/2023 9:16 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	829	27	1,828			1.00
2.00	HMO and other (see instructions)	385	216				2.00
3.00	HMO IPF Subprovider	216	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	70	0	110			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	5			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	899	27	1,943			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)	899	27	1,943	0.00	261.27	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	620	3,459	5,559	0.00	52.18	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	3,658	0	13,142	0.00	13.69	26.00
26.01	RURAL HEALTH CLINIC II	2,390	0	10,149	0.00	12.71	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	339.85	27.00
28.00	Observation Bed Days		0	1,284			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: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 9/11/2023 9:16 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	302	100	636	1.00
2.00	HMO and other (see instructions)			109	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	302	100	636	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	0.00	0	65	446	703	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	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 WAGE INDEX INFORMATION | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 9/11/2023 9:16 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	23,042,735	0	23,042,735	706,885.71	32.60	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		414,739	0	414,739	3,932.75	105.46	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		1,414,611	0	1,414,611	7,907.75	178.89	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		1,016,384	0	1,016,384	47,007.93	21.62	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,540,933	0	3,540,933	117,978.75	30.01	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,685,550	0	2,685,550	21,260.77	126.31	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		3,878,580	0	3,878,580	94,938.38	40.85	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		3,821,421	0	3,821,421			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		834,543	0	834,543			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		44,141	0	44,141			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		113,470	0	113,470			23.00
24.00	Wage-related costs (RHC/FQHC)		302,115	0	302,115			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		1,568,030	0	1,568,030			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-3 Part II Date/Time Prepared: 9/11/2023 9:16 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	91,586	0	91,586	2,171.22	42.18	26.00
27.00	Administrative & General	5.00	3,822,873	0	3,822,873	110,954.40	34.45	27.00
28.00	Administrative & General under contract (see inst.)		520,682	0	520,682	1,207.66	431.15	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	386,872	0	386,872	18,754.71	20.63	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	612,453	0	612,453	37,557.49	16.31	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	674,183	0	674,183	36,412.43	18.52	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	325,435	0	325,435	5,593.52	58.18	38.00
39.00	Central Services and Supply	14.00	286,741	0	286,741	13,528.51	21.20	39.00
40.00	Pharmacy	15.00	598,737	-598,737	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	414,620	0	414,620	19,968.11	20.76	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-3 Part III Date/Time Prepared: 9/11/2023 9:16 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		20,717,683	0	20,717,683	649,244.94	31.91	1.00
2.00	Excluded area salaries (see instructions)		3,540,933	0	3,540,933	117,978.75	30.01	2.00
3.00	Subtotal salaries (line 1 minus line 2)		17,176,750	0	17,176,750	531,266.19	32.33	3.00
4.00	Subtotal other wages & related costs (see inst.)		6,564,130	0	6,564,130	116,199.15	56.49	4.00
5.00	Subtotal wage-related costs (see inst.)		5,389,451	0	5,389,451	0.00	31.38	5.00
6.00	Total (sum of lines 3 thru 5)		29,130,331	0	29,130,331	647,465.34	44.99	6.00
7.00	Total overhead cost (see instructions)		7,734,182	-598,737	7,135,445	246,148.05	28.99	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-3 Part IV | Date/Time Prepared: 9/11/2023 9:16 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	617,368	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,286,536	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	-17,111	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	12,284	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	27,801	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	161,088	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	812,159	17.00
18.00	Medicare Taxes - Employers Portion Only	189,941	18.00
19.00	Unemployment Insurance	19,710	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	5,915	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,115,691	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-3 Part V | Date/Time Prepared: 9/11/2023 9:16 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	3,133,965	5,115,691	1.00
2.00	Hospital	2,685,550	3,881,476	2.00
3.00	SUBPROVIDER - IPF	448,415	694,513	3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	310,287	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	229,415	14.01
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0210 | Component CCN: 14-3473 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-8 | Date/Time Prepared: 9/11/2023 9:16 am

			RHC I	Cost
			1.00	
	Clinic Address and Identification			
1.00	Street		1007 USE ROUTE 45	1.00
		City	State	ZIP Code
		1.00	2.00	3.00
2.00	City, State, ZIP Code, County	ELDORADO	IL	62930 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	20:00	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		SALINE			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	20:00	08:00	20:00	08:00	17:00 11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0210 | Component CCN: 14-3473 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-8 | Date/Time Prepared: 9/11/2023 9:16 am

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	16:50				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0210 | Component CCN: 14-8590 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-8 | Date/Time Prepared: 9/11/2023 9:16 am

RHC II | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			3106 OUTER DRIVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MARION		IL	62959	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:30	16:30	07:30	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?					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		WILLIAMSON				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	16:30	07:30	16:30	07:30	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0210 | Component CCN: 14-8590 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-8 | Date/Time Prepared: 9/11/2023 9:16 am

RHC II | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:30	16:30				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-10 | Date/Time Prepared: 9/11/2023 9:16 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.445708	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,848,711	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	34,928,606	6.00
7.00	Medicaid cost (line 1 times line 6)	15,567,959	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	9,719,248	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	6,437	9.00
10.00	Stand-alone CHIP charges	28,579	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	12,738	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	6,301	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	9,725,549	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,408,046	21,147	1,429,193	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	627,577	21,147	648,724	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	627,577	21,147	648,724	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,281,942	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	275,616	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	424,024	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,857,918	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	976,497	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,625,221	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	11,350,770	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A | Date/Time Prepared: 9/11/2023 9:16 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,538,348	2,538,348	-211,494	2,326,854	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	819,286	819,286	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	91,586	5,260,665	5,352,251	0	5,352,251	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,822,873	6,390,887	10,213,760	-11,223	10,202,537	5.00
7.00	00700	OPERATION OF PLANT	386,872	942,520	1,329,392	128,300	1,457,692	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	97,459	97,459	-7,061	90,398	8.00
9.00	00900	HOUSEKEEPING	612,453	274,312	886,765	-533	886,232	9.00
10.00	01000	DIETARY	674,183	277,005	951,188	0	951,188	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	325,435	16,214	341,649	0	341,649	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	286,741	1,377,400	1,664,141	-1,251,510	412,631	14.00
15.00	01500	PHARMACY	598,737	1,931,049	2,529,786	-2,445,995	83,791	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	414,620	148,007	562,627	-182	562,445	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	414,739	414,739	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,611,435	2,543,498	5,154,933	-787	5,154,146	30.00
40.00	04000	SUBPROVIDER - IPF	3,128,313	2,032,033	5,160,346	-15	5,160,331	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	769,928	507,210	1,277,138	-8,326	1,268,812	50.00
53.00	05300	ANESTHESIOLOGY	414,739	282,826	697,565	-414,739	282,826	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	811,541	229,784	1,041,325	-10,168	1,031,157	54.00
54.01	05401	ULTRASOUND	224,313	99,704	324,017	0	324,017	54.01
54.02	03440	MAMMOGRAPHY	95,590	75,278	170,868	0	170,868	54.02
56.00	05600	RADIOISOTOPE	90,543	155,952	246,495	-45,950	200,545	56.00
57.00	05700	CT SCAN	265,972	166,509	432,481	0	432,481	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	108,233	110,556	218,789	0	218,789	58.00
60.00	06000	LABORATORY	941,452	2,124,609	3,066,061	-60	3,066,001	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	557,593	504,851	1,062,444	-34,951	1,027,493	65.00
66.00	06600	PHYSICAL THERAPY	643,842	17,275	661,117	-228,182	432,935	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	212,665	212,665	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	15,517	15,517	68.00
69.00	06900	ELECTROCARDIOLOGY	87,671	68,000	155,671	0	155,671	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,281,304	1,281,304	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	2,494,480	2,494,480	73.00
75.00	07500	ASC (NON-DISTINCT PART)	846,174	105,636	951,810	0	951,810	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	111,317	7,525	118,842	0	118,842	76.00
76.97	07697	CARDIAC REHABILITATION	97,319	7,968	105,287	0	105,287	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,397,634	258,595	1,656,229	-60,016	1,596,213	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,033,361	624,495	1,657,856	-242,716	1,415,140	88.01
91.00	09100	EMERGENCY	1,179,645	3,332,280	4,511,925	-1,517	4,510,408	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		375,883	375,883	-375,883	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,630,115	32,884,333	55,514,448	14,983	55,529,431	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	301,609	65,029	366,638	-11,769	354,869	192.00
194.00	07950	MARKETING/COMMUNICATION	59,581	37,734	97,315	-3,142	94,173	194.00
194.01	07951	AUXILIARY	51,430	1,059	52,489	0	52,489	194.01
194.02	07952	FOUNDATION	0	55,334	55,334	-72	55,262	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	23,042,735	33,043,489	56,086,224	0	56,086,224	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A | Date/Time Prepared: 9/11/2023 9:16 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	700,478	3,027,332		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	819,286		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-70,679	5,281,572		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,174,334	12,376,871		5.00
7.00	00700	OPERATION OF PLANT	-115,186	1,342,506		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	90,398		8.00
9.00	00900	HOUSEKEEPING	0	886,232		9.00
10.00	01000	DIETARY	-67,140	884,048		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	341,649		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	412,631		14.00
15.00	01500	PHARMACY	0	83,791		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-24,539	537,906		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-414,739	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-915,104	4,239,042		30.00
40.00	04000	SUBPROVIDER - IPF	-1,127,456	4,032,875		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-26,625	1,242,187		50.00
53.00	05300	ANESTHESIOLOGY	-176,338	106,488		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,031,157		54.00
54.01	05401	ULTRASOUND	0	324,017		54.01
54.02	03440	MAMMOGRAPHY	0	170,868		54.02
56.00	05600	RADIOISOTOPE	0	200,545		56.00
57.00	05700	CT SCAN	14	432,495		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	218,789		58.00
60.00	06000	LABORATORY	-3,190	3,062,811		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	-48,443	979,050		65.00
66.00	06600	PHYSICAL THERAPY	147	433,082		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	212,665		67.00
68.00	06800	SPEECH PATHOLOGY	0	15,517		68.00
69.00	06900	ELECTROCARDIOLOGY	-13,610	142,061		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,281,304		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,494,480		73.00
75.00	07500	ASC (NON-DISTINCT PART)	100	951,910		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	118,842		76.00
76.97	07697	CARDIAC REHABILITATION	0	105,287		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,596,213		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,415,140		88.01
91.00	09100	EMERGENCY	-1,067,129	3,443,279		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,195,105	54,334,326		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	354,869		192.00
194.00	07950	MARKETING/COMMUNICATION	0	94,173		194.00
194.01	07951	AUXILIARY	0	52,489		194.01
194.02	07952	FOUNDATION	0	55,262		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,195,105	54,891,119		200.00

RECLASSIFICATIONS | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-6 | Date/Time Prepared: 9/11/2023 9:16 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - INTEREST EXP & BOND AMORT				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	375,883	1.00
	0		0	375,883	
	B - MME DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	806,874	1.00
	0		0	806,874	
	C - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	65,956	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	65,956	
	D - IMPLANTABLE DEVICES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7,620	1.00
	0		0	7,620	
	E - THERAPY				
1.00	OCCUPATIONAL THERAPY	67.00	207,108	5,557	1.00
2.00	SPEECH PATHOLOGY	68.00	15,112	405	2.00
	TOTALS		222,220	5,962	
	F - CRNA COSTS				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	414,739	0	1.00
	0		414,739	0	
	G - OVERHEAD COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	165,953	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	66,438	2.00
3.00	OPERATION OF PLANT	7.00	0	128,300	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	0		0	360,691	
	H - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	598,737	1,895,743	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		598,737	1,895,743	
	I - MEDICAL SUPPLIES CHARGED TO PATIENTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,273,684	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	1,273,684	
500.00	Grand Total: Increases		1,235,696	4,792,413	500.00

RECLASSIFICATIONS | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-6 | Date/Time Prepared: 9/11/2023 9:16 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST EXP & BOND AMORT						
1.00	INTEREST EXPENSE	113.00	0	375,883	11		1.00
	0		0	375,883			
	B - MME DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	806,874	9		1.00
	0		0	806,874			
	C - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	65,956	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	65,956			
	D - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	7,620	0		1.00
	0		0	7,620			
	E - THERAPY						
1.00	PHYSICAL THERAPY	66.00	222,220	5,962	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		222,220	5,962			
	F - CRNA COSTS						
1.00	ANESTHESIOLOGY	53.00	414,739	0	0		1.00
	0		414,739	0			
	G - OVERHEAD COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,705	10		1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	0	7,061	0		2.00
3.00	HOUSEKEEPING	9.00	0	533	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	13,167	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	182	0		5.00
6.00	SUBPROVIDER - IPF	40.00	0	15	0		6.00
7.00	OPERATING ROOM	50.00	0	66	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,168	0		8.00
9.00	LABORATORY	60.00	0	60	0		9.00
10.00	RURAL HEALTH CLINIC	88.00	0	60,016	0		10.00
11.00	RURAL HEALTH CLINIC II	88.01	0	242,716	0		11.00
12.00	EMERGENCY	91.00	0	19	0		12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	11,769	0		13.00
14.00	MARKETING/COMMUNICATION	194.00	0	3,142	0		14.00
15.00	FOUNDATION	194.02	0	72	0		15.00
	0		0	360,691			
	H - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	598,737	1,847,258	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	787	0		2.00
3.00	OPERATING ROOM	50.00	0	83	0		3.00
4.00	RADIOISOTOPE	56.00	0	45,950	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	167	0		5.00
6.00	EMERGENCY	91.00	0	1,498	0		6.00
	TOTALS		598,737	1,895,743			
	I - MEDICAL SUPPLIES CHARGED TO PATIENTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,238,343	0		1.00
2.00	OPERATING ROOM	50.00	0	557	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	34,784	0		3.00
	TOTALS		0	1,273,684			
500.00	Grand Total: Decreases		1,235,696	4,792,413			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 9/11/2023 9:16 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	772,443	0	0	0	0	1.00
2.00	Land Improvements	667,589	0	0	0	513,255	2.00
3.00	Buildings and Fixtures	38,242,567	34,075	0	34,075	17,463,101	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	43,061	0	43,061	0	5.00
6.00	Movable Equipment	18,559,713	292,093	0	292,093	13,801,991	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	58,242,312	369,229	0	369,229	31,778,347	8.00
9.00	Reconciling Items	0	-372,013	0	-372,013	0	9.00
10.00	Total (line 8 minus line 9)	58,242,312	741,242	0	741,242	31,778,347	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	772,443	0	1.00
2.00	Land Improvements	154,334	0	2.00
3.00	Buildings and Fixtures	20,813,541	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	43,061	0	5.00
6.00	Movable Equipment	5,049,815	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	26,833,194	0	8.00
9.00	Reconciling Items	-372,013	0	9.00
10.00	Total (line 8 minus line 9)	27,205,207	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 9/11/2023 9:16 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,538,348	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,538,348	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	2,538,348		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	2,538,348		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 9/11/2023 9:16 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	21,783,379	0	21,783,379	0.811807	53,544	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,049,815	0	5,049,815	0.188193	12,412	2.00
3.00	Total (sum of lines 1-2)	26,833,194	0	26,833,194	1.000000	65,956	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	53,544	2,431,952	165,953	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	12,412	806,874	0	2.00
3.00	Total (sum of lines 1-2)	0	0	65,956	3,238,826	165,953	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	375,883	53,544	0	0	3,027,332	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	12,412	0	0	819,286	2.00
3.00	Total (sum of lines 1-2)	375,883	65,956	0	0	3,846,618	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-8 | Date/Time Prepared: 9/11/2023 9:16 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-897	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,645	ADMINISTRATIVE & GENERAL	5.00	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	-3,394,493			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	6,003,331			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-67,140	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-24,539	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	B	-5,157	ADMINISTRATIVE & GENERAL	5.00	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	A	-414,739	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-10,613	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-8 | Date/Time Prepared: 9/11/2023 9:16 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	RENTAL INCOME	B	-115,220	OPERATION OF PLANT	7.00	0	33.01
34.00	ADVERTISING	A	-13,875	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	CRNA BENEFITS	A	-70,679	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
37.00	CAPITALIZED INTEREST	A	34	OPERATION OF PLANT	7.00	0	37.00
37.01	CAPITALIZED INTEREST	A	75	OPERATING ROOM	50.00	0	37.01
37.02	CAPITALIZED INTEREST	A	14	CT SCAN	57.00	0	37.02
37.03	CAPITALIZED INTEREST	A	147	PHYSICAL THERAPY	66.00	0	37.03
37.04	CAPITALIZED INTEREST	A	100	ASC (NON-DISTINCT PART)	75.00	0	37.04
37.05	CAPITALIZED INTEREST	A	87	EMERGENCY	91.00	0	37.05
38.00	PENALTY FEES	A	-20	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	LOBBYINNG DUES	A	-14,528	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	PHYSICIAN RECRUITMENT	A	-24,528	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	PROVIDER TAX	A	-3,040,820	ADMINISTRATIVE & GENERAL	5.00	0	41.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,195,105				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: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 9/11/2023 9:16 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	SIH HO - CAPITAL	700,478	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	SIH HO - OPERATING	5,302,853	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,003,331	0	5.00

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

				Related Organization(s) and/or Home Office		
	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	SIH	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: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 9/11/2023 9:16 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	700,478	9		1.00
2.00	5,302,853	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	6,003,331			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	HOME OFFICE		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: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 9/11/2023 9:16 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	16,436	16,436	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	915,104	915,104	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	1,127,456	1,127,456	0	0	0	3.00
4.00	50.00	OPERATING ROOM	26,700	26,700	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	176,338	176,338	0	0	0	5.00
6.00	60.00	LABORATORY	3,190	3,190	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	48,443	48,443	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	13,610	13,610	0	0	0	8.00
9.00	91.00	EMERGENCY	1,067,216	1,067,216	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,394,493	3,394,493	0		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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	13,136	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	3,337	0	45,504	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	3,337	0	58,640	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	16,436		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	915,104		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	1,127,456		3.00
4.00	50.00	OPERATING ROOM	0	0	0	26,700		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	176,338		5.00
6.00	60.00	LABORATORY	0	0	0	3,190		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	48,443		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	13,610		8.00
9.00	91.00	EMERGENCY	0	0	0	1,067,216		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,394,493		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part I Date/Time Prepared: 9/11/2023 9:16 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,027,332	3,027,332				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	819,286		819,286			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,281,572	38,386	207	5,320,165		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,376,871	311,356	172,144	954,716	13,815,087	5.00
7.00	00700	OPERATION OF PLANT	1,342,506	62,262	5,073	96,616	1,506,457	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	90,398	4,505	4,099	0	99,002	8.00
9.00	00900	HOUSEKEEPING	886,232	11,262	676	152,952	1,051,122	9.00
10.00	01000	DIETARY	884,048	55,149	0	168,368	1,107,565	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	341,649	12,519	978	81,273	436,419	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	412,631	121,560	11,897	71,610	617,698	14.00
15.00	01500	PHARMACY	83,791	19,821	61,756	0	165,368	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	537,906	15,625	1,065	103,546	658,142	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,239,042	223,061	65,686	652,169	5,179,958	30.00
40.00	04000	SUBPROVIDER - IPF	4,032,875	343,080	12,698	740,163	5,128,816	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,242,187	165,423	101,049	192,279	1,700,938	50.00
53.00	05300	ANESTHESIOLOGY	106,488	0	3,299	0	109,787	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,031,157	51,545	13,550	202,671	1,298,923	54.00
54.01	05401	ULTRASOUND	324,017	11,831	12,499	56,019	404,366	54.01
54.02	03440	MAMMOGRAPHY	170,868	7,303	0	23,872	202,043	54.02
56.00	05600	RADIOISOTOPE	200,545	44,290	460	22,612	267,907	56.00
57.00	05700	CT SCAN	432,495	12,471	1,431	66,423	512,820	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	218,789	358,114	139,366	27,030	743,299	58.00
60.00	06000	LABORATORY	3,062,811	68,142	76,461	235,114	3,442,528	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	979,050	31,415	16,739	139,251	1,166,455	65.00
66.00	06600	PHYSICAL THERAPY	433,082	79,262	5,002	105,294	622,640	66.00
67.00	06700	OCCUPATIONAL THERAPY	212,665	4,552	0	51,722	268,939	67.00
68.00	06800	SPEECH PATHOLOGY	15,517	0	0	3,774	19,291	68.00
69.00	06900	ELECTROCARDIOLOGY	142,061	38,979	6,615	21,895	209,550	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,281,304	0	0	0	1,281,304	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,494,480	0	0	149,526	2,644,006	73.00
75.00	07500	ASC (NON-DISTINCT PART)	951,910	130,522	38,367	211,320	1,332,119	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	118,842	26,484	6,941	27,800	180,067	76.00
76.97	07697	CARDIAC REHABILITATION	105,287	0	7,298	24,304	136,889	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,596,213	277,380	6,660	191,268	2,071,521	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,415,140	228,491	4,129	161,130	1,808,890	88.01
91.00	09100	EMERGENCY	3,443,279	155,014	26,565	294,600	3,919,458	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,334,326	2,909,804	802,710	5,229,317	54,109,374	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	354,869	95,455	15,418	63,124	528,866	192.00
194.00	07950	MARKETING/COMMUNICATION	94,173	5,690	1,158	14,880	115,901	194.00
194.01	07951	AUXILIARY	52,489	16,383	0	12,844	81,716	194.01
194.02	07952	FOUNDATION	55,262	0	0	0	55,262	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	54,891,119	3,027,332	819,286	5,320,165	54,891,119	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part I | Date/Time Prepared: 9/11/2023 9:16 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,815,087					5.00
7.00	00700	OPERATION OF PLANT	506,667	2,013,124				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,297	3,468	135,767			8.00
9.00	00900	HOUSEKEEPING	353,524	8,669	0	1,413,315		9.00
10.00	01000	DIETARY	372,507	42,450	0	0	1,522,522	10.00
11.00	01100	CAFETERIA	0	0	0	0	314,240	11.00
13.00	01300	NURSING ADMINISTRATION	146,781	9,636	0	13,467	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	207,750	93,570	0	0	0	14.00
15.00	01500	PHARMACY	55,618	15,257	0	16,833	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	221,353	12,027	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,742,159	171,699	29,721	355,518	779,343	30.00
40.00	04000	SUBPROVIDER - IPF	1,724,975	264,083	18,701	222,871	325,872	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	572,076	127,333	12,170	86,859	0	50.00
53.00	05300	ANESTHESIOLOGY	36,925	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	436,867	39,676	11,874	0	0	54.00
54.01	05401	ULTRASOUND	136,000	9,107	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	67,953	5,621	0	0	0	54.02
56.00	05600	RADIOISOTOPE	90,105	34,092	0	0	0	56.00
57.00	05700	CT SCAN	172,477	9,600	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	249,994	275,651	0	0	0	58.00
60.00	06000	LABORATORY	1,157,825	52,452	0	41,073	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	392,314	24,182	6,011	32,320	0	65.00
66.00	06600	PHYSICAL THERAPY	209,413	61,011	5,195	30,300	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	90,452	3,504	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,488	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	70,478	30,004	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	430,941	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	889,259	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	448,032	100,468	14,990	117,832	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	60,562	20,386	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	46,040	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	696,715	213,511	17,810	98,979	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	608,384	175,879	7,421	98,979	0	88.01
91.00	09100	EMERGENCY	1,318,231	119,321	11,874	298,284	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,552,162	1,922,657	135,767	1,413,315	1,419,455	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	177,874	73,476	0	0	103,067	192.00
194.00	07950	MARKETING/COMMUNICATION	38,981	4,380	0	0	0	194.00
194.01	07951	AUXILIARY	27,484	12,611	0	0	0	194.01
194.02	07952	FOUNDATION	18,586	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,815,087	2,013,124	135,767	1,413,315	1,522,522	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part I | Date/Time Prepared: 9/11/2023 9:16 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	314,240					11.00
13.00	01300	NURSING ADMINISTRATION	3,955	610,258				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,564	0	928,582			14.00
15.00	01500	PHARMACY	8,398	0	22,078	283,552		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,116	0	2,627	0	908,265	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,631	154,869	209,924	0	50,158	30.00
40.00	04000	SUBPROVIDER - IPF	76,734	229,320	49,680	0	58,333	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,002	41,998	93,844	0	53,640	50.00
53.00	05300	ANESTHESIOLOGY	0	0	18,444	0	16,063	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,876	0	7,544	0	31,464	54.00
54.01	05401	ULTRASOUND	4,037	0	19,803	0	34,861	54.01
54.02	03440	MAMMOGRAPHY	1,355	0	2,246	0	4,000	54.02
56.00	05600	RADIOISOTOPE	1,429	0	3,843	0	15,317	56.00
57.00	05700	CT SCAN	4,747	0	17,786	0	150,195	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,471	0	3,056	0	33,747	58.00
60.00	06000	LABORATORY	26,956	0	35,875	0	144,574	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	11,307	0	29,878	0	20,280	65.00
66.00	06600	PHYSICAL THERAPY	11,834	0	6,370	0	13,761	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,898	0	596	0	6,759	67.00
68.00	06800	SPEECH PATHOLOGY	284	0	15	0	493	68.00
69.00	06900	ELECTROCARDIOLOGY	2,114	0	3,468	0	5,636	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	25,721	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	283,552	69,691	73.00
75.00	07500	ASC (NON-DISTINCT PART)	14,729	44,180	106,757	0	35,192	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	2,166	6,497	11,947	0	2,248	76.00
76.97	07697	CARDIAC REHABILITATION	1,277	3,830	3,236	0	3,566	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	51,740	18,946	0	15,830	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	12,991	0	15,422	88.01
91.00	09100	EMERGENCY	25,945	77,824	242,741	0	101,314	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	309,825	610,258	923,695	283,552	908,265	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,393	0	3,315	0	0	192.00
194.00	07950	MARKETING/COMMUNICATION	1,120	0	1,367	0	0	194.00
194.01	07951	AUXILIARY	1,902	0	205	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	314,240	610,258	928,582	283,552	908,265	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part I | Date/Time Prepared: 9/11/2023 9:16 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	8,724,980	-1,176,295	7,548,685		30.00
40.00	04000	SUBPROVIDER - IPF	0	8,099,385	0	8,099,385		40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,702,860	0	2,702,860		50.00
53.00	05300	ANESTHESIOLOGY	0	181,219	0	181,219		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,844,224	0	1,844,224		54.00
54.01	05401	ULTRASOUND	0	608,174	0	608,174		54.01
54.02	03440	MAMMOGRAPHY	0	283,218	0	283,218		54.02
56.00	05600	RADIOISOTOPE	0	412,693	0	412,693		56.00
57.00	05700	CT SCAN	0	867,625	0	867,625		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,307,218	0	1,307,218		58.00
60.00	06000	LABORATORY	0	4,901,283	0	4,901,283		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	1,176,295	1,176,295		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,682,747	0	1,682,747		65.00
66.00	06600	PHYSICAL THERAPY	0	960,524	0	960,524		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	374,148	0	374,148		67.00
68.00	06800	SPEECH PATHOLOGY	0	26,571	0	26,571		68.00
69.00	06900	ELECTROCARDIOLOGY	0	321,250	0	321,250		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,737,966	0	1,737,966		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,886,508	0	3,886,508		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	2,214,299	0	2,214,299		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	283,873	0	283,873		76.00
76.97	07697	CARDIAC REHABILITATION	0	194,838	0	194,838		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,185,052	0	3,185,052		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,727,966	0	2,727,966		88.01
91.00	09100	EMERGENCY	0	6,114,992	0	6,114,992		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	53,643,613	0	53,643,613		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	887,991	0	887,991		192.00
194.00	07950	MARKETING/COMMUNICATION	0	161,749	0	161,749		194.00
194.01	07951	AUXILIARY	0	123,918	0	123,918		194.01
194.02	07952	FOUNDATION	0	73,848	0	73,848		194.02
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	54,891,119	0	54,891,119		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part II Date/Time Prepared: 9/11/2023 9:16 am

		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	38,386	207	38,593	38,593	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,518	311,356	172,144	486,018	6,919	5.00
7.00	00700	OPERATION OF PLANT	0	62,262	5,073	67,335	701	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,505	4,099	8,604	0	8.00
9.00	00900	HOUSEKEEPING	0	11,262	676	11,938	1,110	9.00
10.00	01000	DIETARY	0	55,149	0	55,149	1,222	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	12,519	978	13,497	590	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,522	121,560	11,897	134,979	520	14.00
15.00	01500	PHARMACY	0	19,821	61,756	81,577	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,625	1,065	16,690	751	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,466	223,061	65,686	294,213	4,732	30.00
40.00	04000	SUBPROVIDER - IPF	0	343,080	12,698	355,778	5,370	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	254,640	165,423	101,049	521,112	1,395	50.00
53.00	05300	ANESTHESIOLOGY	3,478	0	3,299	6,777	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	51,545	13,550	65,095	1,471	54.00
54.01	05401	ULTRASOUND	0	11,831	12,499	24,330	406	54.01
54.02	03440	MAMMOGRAPHY	0	7,303	0	7,303	173	54.02
56.00	05600	RADIOISOTOPE	0	44,290	460	44,750	164	56.00
57.00	05700	CT SCAN	0	12,471	1,431	13,902	482	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	358,114	139,366	497,480	196	58.00
60.00	06000	LABORATORY	0	68,142	76,461	144,603	1,706	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	24,576	31,415	16,739	72,730	1,010	65.00
66.00	06600	PHYSICAL THERAPY	0	79,262	5,002	84,264	764	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,552	0	4,552	375	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	27	68.00
69.00	06900	ELECTROCARDIOLOGY	27,290	38,979	6,615	72,884	159	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,085	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	130,522	38,367	168,889	1,533	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	26,484	6,941	33,425	202	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	7,298	7,298	176	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	444	277,380	6,660	284,484	1,388	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,400	228,491	4,129	238,020	1,169	88.01
91.00	09100	EMERGENCY	0	155,014	26,565	181,579	2,138	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	325,334	2,909,804	802,710	4,037,848	37,934	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,418	95,455	15,418	118,291	458	192.00
194.00	07950	MARKETING/COMMUNICATION	0	5,690	1,158	6,848	108	194.00
194.01	07951	AUXILIARY	0	16,383	0	16,383	93	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	332,752	3,027,332	819,286	4,179,370	38,593	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part II | Date/Time Prepared: 9/11/2023 9:16 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	492,937					5.00
7.00	00700	OPERATION OF PLANT	18,079	86,115				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,188	148	9,940			8.00
9.00	00900	HOUSEKEEPING	12,615	371	0	26,034		9.00
10.00	01000	DIETARY	13,292	1,816	0	0	71,479	10.00
11.00	01100	CAFETERIA	0	0	0	0	14,753	11.00
13.00	01300	NURSING ADMINISTRATION	5,237	412	0	248	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,413	4,003	0	0	0	14.00
15.00	01500	PHARMACY	1,985	653	0	310	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,898	514	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	62,147	7,345	2,177	6,549	36,588	30.00
40.00	04000	SUBPROVIDER - IPF	61,551	11,297	1,369	4,105	15,299	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,413	5,447	891	1,600	0	50.00
53.00	05300	ANESTHESIOLOGY	1,318	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,588	1,697	869	0	0	54.00
54.01	05401	ULTRASOUND	4,853	390	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	2,425	240	0	0	0	54.02
56.00	05600	RADIOISOTOPE	3,215	1,458	0	0	0	56.00
57.00	05700	CT SCAN	6,154	411	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,920	11,792	0	0	0	58.00
60.00	06000	LABORATORY	41,314	2,244	0	757	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	13,999	1,034	440	595	0	65.00
66.00	06600	PHYSICAL THERAPY	7,472	2,610	380	558	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,228	150	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	232	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,515	1,283	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,377	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	31,731	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	15,987	4,298	1,098	2,171	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	2,161	872	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,643	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	24,860	9,133	1,304	1,823	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	21,708	7,524	543	1,823	0	88.01
91.00	09100	EMERGENCY	47,037	5,104	869	5,495	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	483,555	82,246	9,940	26,034	66,640	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,347	3,143	0	0	4,839	192.00
194.00	07950	MARKETING/COMMUNICATION	1,391	187	0	0	0	194.00
194.01	07951	AUXILIARY	981	539	0	0	0	194.01
194.02	07952	FOUNDATION	663	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	492,937	86,115	9,940	26,034	71,479	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part II | Date/Time Prepared: 9/11/2023 9:16 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	14,753					11.00
13.00	01300	NURSING ADMINISTRATION	186	20,170				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	449	0	147,364			14.00
15.00	01500	PHARMACY	394	0	3,504	88,423		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	663	0	417	0	26,933	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,424	5,119	33,314	0	1,489	30.00
40.00	04000	SUBPROVIDER - IPF	3,602	7,579	7,884	0	1,732	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	657	1,388	14,893	0	1,592	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,927	0	477	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	839	0	1,197	0	934	54.00
54.01	05401	ULTRASOUND	190	0	3,143	0	1,035	54.01
54.02	03440	MAMMOGRAPHY	64	0	356	0	119	54.02
56.00	05600	RADIOISOTOPE	67	0	610	0	455	56.00
57.00	05700	CT SCAN	223	0	2,823	0	4,427	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	69	0	485	0	1,002	58.00
60.00	06000	LABORATORY	1,266	0	5,693	0	4,292	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	531	0	4,742	0	602	65.00
66.00	06600	PHYSICAL THERAPY	556	0	1,011	0	408	66.00
67.00	06700	OCCUPATIONAL THERAPY	183	0	95	0	201	67.00
68.00	06800	SPEECH PATHOLOGY	13	0	2	0	15	68.00
69.00	06900	ELECTROCARDIOLOGY	99	0	550	0	167	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	764	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	88,423	2,069	73.00
75.00	07500	ASC (NON-DISTINCT PART)	691	1,460	16,942	0	1,045	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	102	215	1,896	0	67	76.00
76.97	07697	CARDIAC REHABILITATION	60	127	513	0	106	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,710	3,007	0	470	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	2,062	0	458	88.01
91.00	09100	EMERGENCY	1,218	2,572	38,522	0	3,007	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,546	20,170	146,588	88,423	26,933	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	65	0	526	0	0	192.00
194.00	07950	MARKETING/COMMUNICATION	53	0	217	0	0	194.00
194.01	07951	AUXILIARY	89	0	33	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,753	20,170	147,364	88,423	26,933	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part II | Date/Time Prepared: 9/11/2023 9:16 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		456,097	0	456,097		30.00
40.00	04000	SUBPROVIDER - IPF		475,566	0	475,566		40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		569,388	0	569,388		50.00
53.00	05300	ANESTHESIOLOGY		11,499	0	11,499		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		87,690	0	87,690		54.00
54.01	05401	ULTRASOUND		34,347	0	34,347		54.01
54.02	03440	MAMMOGRAPHY		10,680	0	10,680		54.02
56.00	05600	RADIOISOTOPE		50,719	0	50,719		56.00
57.00	05700	CT SCAN		28,422	0	28,422		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		519,944	0	519,944		58.00
60.00	06000	LABORATORY		201,875	0	201,875		60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY		95,683	0	95,683		65.00
66.00	06600	PHYSICAL THERAPY		98,023	0	98,023		66.00
67.00	06700	OCCUPATIONAL THERAPY		8,784	0	8,784		67.00
68.00	06800	SPEECH PATHOLOGY		289	0	289		68.00
69.00	06900	ELECTROCARDIOLOGY		77,657	0	77,657		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		16,141	0	16,141		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		123,308	0	123,308		73.00
75.00	07500	ASC (NON-DISTINCT PART)		214,114	0	214,114		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY		38,940	0	38,940		76.00
76.97	07697	CARDIAC REHABILITATION		9,923	0	9,923		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		328,179	0	328,179		88.00
88.01	08801	RURAL HEALTH CLINIC II		273,307	0	273,307		88.01
91.00	09100	EMERGENCY		287,541	0	287,541		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM		0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,018,116	0	4,018,116		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES		133,669	0	133,669		192.00
194.00	07950	MARKETING/COMMUNICATION		8,804	0	8,804		194.00
194.01	07951	AUXILIARY		18,118	0	18,118		194.01
194.02	07952	FOUNDATION		663	0	663		194.02
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,179,370	0	4,179,370		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B-1 | Date/Time Prepared: 9/11/2023 9:16 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	127,683					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		806,874				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,619	204	21,303,121			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,132	169,536	3,822,873	-13,815,087	41,076,032	5.00
7.00	00700	OPERATION OF PLANT	2,626	4,996	386,872	0	1,506,457	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	190	4,037	0	0	99,002	8.00
9.00	00900	HOUSEKEEPING	475	666	612,453	0	1,051,122	9.00
10.00	01000	DIETARY	2,326	0	674,183	0	1,107,565	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	528	963	325,435	0	436,419	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,127	11,717	286,741	0	617,698	14.00
15.00	01500	PHARMACY	836	60,820	0	0	165,368	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	659	1,049	414,620	0	658,142	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,408	64,691	2,611,435	0	5,179,958	30.00
40.00	04000	SUBPROVIDER - IPF	14,470	12,506	2,963,781	0	5,128,816	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,977	99,518	769,928	0	1,700,938	50.00
53.00	05300	ANESTHESIOLOGY	0	3,249	0	0	109,787	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,174	13,345	811,541	0	1,298,923	54.00
54.01	05401	ULTRASOUND	499	12,310	224,313	0	404,366	54.01
54.02	03440	MAMMOGRAPHY	308	0	95,590	0	202,043	54.02
56.00	05600	RADIOISOTOPE	1,868	453	90,543	0	267,907	56.00
57.00	05700	CT SCAN	526	1,409	265,972	0	512,820	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,104	137,255	108,233	0	743,299	58.00
60.00	06000	LABORATORY	2,874	75,303	941,452	0	3,442,528	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,325	16,485	557,593	0	1,166,455	65.00
66.00	06600	PHYSICAL THERAPY	3,343	4,926	421,622	0	622,640	66.00
67.00	06700	OCCUPATIONAL THERAPY	192	0	207,108	0	268,939	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	15,112	0	19,291	68.00
69.00	06900	ELECTROCARDIOLOGY	1,644	6,515	87,671	0	209,550	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,281,304	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	598,737	0	2,644,006	73.00
75.00	07500	ASC (NON-DISTINCT PART)	5,505	37,786	846,174	0	1,332,119	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	1,117	6,836	111,317	0	180,067	76.00
76.97	07697	CARDIAC REHABILITATION	0	7,187	97,319	0	136,889	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	11,699	6,559	765,880	0	2,071,521	88.00
88.01	08801	RURAL HEALTH CLINIC II	9,637	4,066	645,203	0	1,808,890	88.01
91.00	09100	EMERGENCY	6,538	26,163	1,179,645	0	3,919,458	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	122,726	790,550	20,939,346	-13,815,087	40,294,287	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,026	15,184	252,764	0	528,866	192.00
194.00	07950	MARKETING/COMMUNICATION	240	1,140	59,581	0	115,901	194.00
194.01	07951	AUXILIARY	691	0	51,430	0	81,716	194.01
194.02	07952	FOUNDATION	0	0	0	0	55,262	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,027,332	819,286	5,320,165		13,815,087	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.709750	1.015383	0.249736		0.336330	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			38,593		492,937	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001812		0.012001	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: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B-1 | Date/Time Prepared: 9/11/2023 9:16 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (MEALS SERVED)	CAFETERIA (ASSIGNED TIME)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	110,306					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	190	36,590				8.00
9.00	00900	HOUSEKEEPING	475	0	2,099			9.00
10.00	01000	DIETARY	2,326	0	0	121,205		10.00
11.00	01100	CAFETERIA	0	0	0	25,016	444,510	11.00
13.00	01300	NURSING ADMINISTRATION	528	0	20	0	5,594	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,127	0	0	0	13,529	14.00
15.00	01500	PHARMACY	836	0	25	0	11,879	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	659	0	0	0	19,968	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,408	8,010	528	62,042	73,035	30.00
40.00	04000	SUBPROVIDER - IPF	14,470	5,040	331	25,942	108,544	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,977	3,280	129	0	19,806	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,174	3,200	0	0	25,287	54.00
54.01	05401	ULTRASOUND	499	0	0	0	5,710	54.01
54.02	03440	MAMMOGRAPHY	308	0	0	0	1,917	54.02
56.00	05600	RADIOISOTOPE	1,868	0	0	0	2,022	56.00
57.00	05700	CT SCAN	526	0	0	0	6,715	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,104	0	0	0	2,081	58.00
60.00	06000	LABORATORY	2,874	0	61	0	38,131	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,325	1,620	48	0	15,994	65.00
66.00	06600	PHYSICAL THERAPY	3,343	1,400	45	0	16,740	66.00
67.00	06700	OCCUPATIONAL THERAPY	192	0	0	0	5,514	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	402	68.00
69.00	06900	ELECTROCARDIOLOGY	1,644	0	0	0	2,990	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	5,505	4,040	175	0	20,835	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	1,117	0	0	0	3,064	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	1,806	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	11,699	4,800	147	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	9,637	2,000	147	0	0	88.01
91.00	09100	EMERGENCY	6,538	3,200	443	0	36,701	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	105,349	36,590	2,099	113,000	438,264	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,026	0	0	8,205	1,971	192.00
194.00	07950	MARKETING/COMMUNICATION	240	0	0	0	1,584	194.00
194.01	07951	AUXILIARY	691	0	0	0	2,691	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,013,124	135,767	1,413,315	1,522,522	314,240	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.250358	3.710495	673.327775	12.561544	0.706936	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	86,115	9,940	26,034	71,479	14,753	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.780692	0.271659	12.403049	0.589736	0.033189	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: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B-1 | Date/Time Prepared: 9/11/2023 9:16 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	287,793					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	512,273				14.00
15.00	01500	PHARMACY	0	12,180	1,895,743			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,449	0	120,355,889		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	73,035	115,809	0	6,646,985	0	30.00
40.00	04000	SUBPROVIDER - IPF	108,146	27,407	0	7,730,325	0	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,806	51,771	0	7,108,459	0	50.00
53.00	05300	ANESTHESIOLOGY	0	10,175	0	2,128,735	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,162	0	4,169,671	0	54.00
54.01	05401	ULTRASOUND	0	10,925	0	4,619,753	0	54.01
54.02	03440	MAMMOGRAPHY	0	1,239	0	530,069	0	54.02
56.00	05600	RADIOISOTOPE	0	2,120	0	2,029,786	0	56.00
57.00	05700	CT SCAN	0	9,812	0	19,895,723	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,686	0	4,472,214	0	58.00
60.00	06000	LABORATORY	0	19,791	0	19,159,037	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	16,483	0	2,687,526	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,514	0	1,823,555	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	329	0	895,761	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	8	0	65,362	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,913	0	746,832	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,408,588	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	1,895,743	9,235,532	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	20,835	58,895	0	4,663,663	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	3,064	6,591	0	297,964	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,806	1,785	0	472,552	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	24,400	10,452	0	2,097,813	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	7,167	0	2,043,795	0	88.01
91.00	09100	EMERGENCY	36,701	133,914	0	13,426,189	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	287,793	509,577	1,895,743	120,355,889	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,829	0	0	0	192.00
194.00	07950	MARKETING/COMMUNICATION	0	754	0	0	0	194.00
194.01	07951	AUXILIARY	0	113	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	610,258	928,582	283,552	908,265	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.120475	1.812670	0.149573	0.007546	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	20,170	147,364	88,423	26,933	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.070085	0.287667	0.046643	0.000224	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B-2 | Date/Time Prepared: 9/11/2023 9:16 am

		Description	Worksheet CODE	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		ADULTS & PEDIATRICS	1	30.00	-1,176,295	7.00
8.00		IV THERAPY	1	64.00	1,176,295	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet C Part I Date/Time Prepared: 9/11/2023 9:16 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,548,685		7,548,685	0	7,548,685	30.00
40.00	04000	SUBPROVIDER - IPF	8,099,385		8,099,385	0	8,099,385	40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,702,860		2,702,860	0	2,702,860	50.00
53.00	05300	ANESTHESIOLOGY	181,219		181,219	0	181,219	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,844,224		1,844,224	0	1,844,224	54.00
54.01	05401	ULTRASOUND	608,174		608,174	0	608,174	54.01
54.02	03440	MAMMOGRAPHY	283,218		283,218	0	283,218	54.02
56.00	05600	RADIOISOTOPE	412,693		412,693	0	412,693	56.00
57.00	05700	CT SCAN	867,625		867,625	0	867,625	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,307,218		1,307,218	0	1,307,218	58.00
60.00	06000	LABORATORY	4,901,283		4,901,283	0	4,901,283	60.00
64.00	06400	INTRAVENOUS THERAPY	1,176,295		1,176,295	0	1,176,295	64.00
65.00	06500	RESPIRATORY THERAPY	1,682,747	0	1,682,747	0	1,682,747	65.00
66.00	06600	PHYSICAL THERAPY	960,524	0	960,524	0	960,524	66.00
67.00	06700	OCCUPATIONAL THERAPY	374,148	0	374,148	0	374,148	67.00
68.00	06800	SPEECH PATHOLOGY	26,571	0	26,571	0	26,571	68.00
69.00	06900	ELECTROCARDIOLOGY	321,250		321,250	0	321,250	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,737,966		1,737,966	0	1,737,966	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,886,508		3,886,508	0	3,886,508	73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,214,299		2,214,299	0	2,214,299	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	283,873		283,873	0	283,873	76.00
76.97	07697	CARDIAC REHABILITATION	194,838		194,838	0	194,838	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,185,052		3,185,052	0	3,185,052	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,727,966		2,727,966	0	2,727,966	88.01
91.00	09100	EMERGENCY	6,114,992		6,114,992	0	6,114,992	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,114,149		3,114,149		3,114,149	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	56,757,762	0	56,757,762	0	56,757,762	200.00
201.00		Less Observation Beds	3,114,149		3,114,149		3,114,149	201.00
202.00		Total (see instructions)	53,643,613	0	53,643,613	0	53,643,613	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet C Part I Date/Time Prepared: 9/11/2023 9:16 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,062,905		2,062,905			30.00
40.00	04000	SUBPROVIDER - IPF	7,730,325		7,730,325			40.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	278,402	6,830,057	7,108,459	0.380231	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	53,290	2,075,445	2,128,735	0.085130	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	105,785	4,063,886	4,169,671	0.442295	0.000000	54.00
54.01	05401	ULTRASOUND	321,582	4,298,171	4,619,753	0.131646	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	530,069	530,069	0.534304	0.000000	54.02
56.00	05600	RADIOISOTOPE	28,847	2,000,939	2,029,786	0.203318	0.000000	56.00
57.00	05700	CT SCAN	936,675	18,959,048	19,895,723	0.043609	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	144,729	4,327,485	4,472,214	0.292298	0.000000	58.00
60.00	06000	LABORATORY	1,702,296	17,456,741	19,159,037	0.255821	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	443,542	1,087,188	1,530,730	0.768454	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,436,249	1,251,277	2,687,526	0.626132	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	495,329	1,328,226	1,823,555	0.526732	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	396,682	499,079	895,761	0.417687	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	6,862	58,500	65,362	0.406521	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	114,240	632,592	746,832	0.430150	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	379,836	3,028,752	3,408,588	0.509879	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,620,064	7,615,468	9,235,532	0.420821	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	14,428	4,649,235	4,663,663	0.474798	0.000000	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	297,964	297,964	0.952709	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	278	472,274	472,552	0.412310	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,097,813	2,097,813			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,043,795	2,043,795			88.01
91.00	09100	EMERGENCY	790,437	12,635,752	13,426,189	0.455453	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	702,890	2,350,460	3,053,350	1.019912	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	19,765,673	100,590,216	120,355,889			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	19,765,673	100,590,216	120,355,889			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet C Part I Date/Time Prepared: 9/11/2023 9:16 am

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
40.00	04000	SUBPROVIDER - IPF		40.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.380231	50.00
53.00	05300	ANESTHESIOLOGY	0.085130	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.442295	54.00
54.01	05401	ULTRASOUND	0.131646	54.01
54.02	03440	MAMMOGRAPHY	0.534304	54.02
56.00	05600	RADIOISOTOPE	0.203318	56.00
57.00	05700	CT SCAN	0.043609	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.292298	58.00
60.00	06000	LABORATORY	0.255821	60.00
64.00	06400	INTRAVENOUS THERAPY	0.768454	64.00
65.00	06500	RESPIRATORY THERAPY	0.626132	65.00
66.00	06600	PHYSICAL THERAPY	0.526732	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.417687	67.00
68.00	06800	SPEECH PATHOLOGY	0.406521	68.00
69.00	06900	ELECTROCARDIOLOGY	0.430150	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.509879	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.420821	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.474798	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.952709	76.00
76.97	07697	CARDIAC REHABILITATION	0.412310	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
91.00	09100	EMERGENCY	0.455453	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.019912	92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part I Date/Time Prepared: 9/11/2023 9:16 am

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	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	456,097	61	456,036	3,112	146.54	30.00
40.00	SUBPROVIDER - IPF	475,566	0	475,566	5,559	85.55	40.00
200.00	Total (lines 30 through 199)	931,663		931,602	8,671		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	829	121,482				30.00
40.00	SUBPROVIDER - IPF	620	53,041				40.00
200.00	Total (lines 30 through 199)	1,449	174,523				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part II Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | 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	569,388	7,108,459	0.080100	151,669	12,149	50.00
53.00	05300	ANESTHESIOLOGY	11,499	2,128,735	0.005402	31,191	168	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,690	4,169,671	0.021030	98,739	2,076	54.00
54.01	05401	ULTRASOUND	34,347	4,619,753	0.007435	206,049	1,532	54.01
54.02	03440	MAMMOGRAPHY	10,680	530,069	0.020148	0	0	54.02
56.00	05600	RADIOISOTOPE	50,719	2,029,786	0.024987	22,362	559	56.00
57.00	05700	CT SCAN	28,422	19,895,723	0.001429	910,994	1,302	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	519,944	4,472,214	0.116261	116,748	13,573	58.00
60.00	06000	LABORATORY	201,875	19,159,037	0.010537	1,119,073	11,792	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,530,730	0.000000	203,303	0	64.00
65.00	06500	RESPIRATORY THERAPY	95,683	2,687,526	0.035603	717,762	25,554	65.00
66.00	06600	PHYSICAL THERAPY	98,023	1,823,555	0.053754	235,675	12,668	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,784	895,761	0.009806	188,526	1,849	67.00
68.00	06800	SPEECH PATHOLOGY	289	65,362	0.004422	3,114	14	68.00
69.00	06900	ELECTROCARDIOLOGY	77,657	746,832	0.103982	105,804	11,002	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,141	3,408,588	0.004735	251,761	1,192	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	123,308	9,235,532	0.013351	523,296	6,987	73.00
75.00	07500	ASC (NON-DISTINCT PART)	214,114	4,663,663	0.045911	6,296	289	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	38,940	297,964	0.130687	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	9,923	472,552	0.020999	278	6	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	328,179	2,097,813	0.156439	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	273,307	2,043,795	0.133725	0	0	88.01
91.00	09100	EMERGENCY	287,541	13,426,189	0.021416	549,144	11,760	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	188,160	3,053,350	0.061624	314,356	19,372	92.00
200.00		Total (lines 50 through 199)	3,274,613	110,562,659		5,756,140	133,844	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part III Date/Time Prepared: 9/11/2023 9:16 am

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		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
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
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	3,112	0.00	829	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	5,559	0.00	620	40.00
200.00		Total (lines 30 through 199)		0	8,671		1,449	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
40.00	04000	SUBPROVIDER - IPF	0	40.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part IV Date/Time Prepared: 9/11/2023 9:16 am

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
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: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part IV Date/Time Prepared: 9/11/2023 9:16 am

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		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	7,108,459	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,128,735	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,169,671	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	4,619,753	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	530,069	0.000000	54.02
56.00	05600	RADIOISOTOPE	0	0	0	2,029,786	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	19,895,723	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	4,472,214	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	19,159,037	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,530,730	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,687,526	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,823,555	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	895,761	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	65,362	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	746,832	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,408,588	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,235,532	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	4,663,663	0.000000	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0	0	297,964	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	472,552	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,097,813	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,043,795	0.000000	88.01
91.00	09100	EMERGENCY	0	0	0	13,426,189	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,053,350	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	110,562,659		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part IV | Date/Time Prepared: 9/11/2023 9:16 am

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		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	151,669	0	2,014,575	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	31,191	0	593,203	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	98,739	0	1,079,186	0	54.00
54.01	05401	ULTRASOUND	0.000000	206,049	0	1,523,494	0	54.01
54.02	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.000000	22,362	0	800,231	0	56.00
57.00	05700	CT SCAN	0.000000	910,994	0	5,355,464	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	116,748	0	1,311,936	0	58.00
60.00	06000	LABORATORY	0.000000	1,119,073	0	2,212,275	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	203,303	0	397,763	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	717,762	0	310,933	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	235,675	0	36,812	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	188,526	0	27,162	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	3,114	0	893	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	105,804	0	530,461	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	251,761	0	1,241,752	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	523,296	0	4,488,924	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	6,296	0	1,390,198	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.000000	0	0	151,114	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	278	0	204,328	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
91.00	09100	EMERGENCY	0.000000	549,144	0	2,547,218	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	314,356	0	745,686	0	92.00
200.00		Total (lines 50 through 199)		5,756,140	0	26,963,608	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part V Date/Time Prepared: 9/11/2023 9:16 am

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		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	0.380231	2,014,575	0	0	766,004	50.00
53.00	05300	ANESTHESIOLOGY	0.085130	593,203	0	0	50,499	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.442295	1,079,186	0	0	477,319	54.00
54.01	05401	ULTRASOUND	0.131646	1,523,494	0	0	200,562	54.01
54.02	03440	MAMMOGRAPHY	0.534304	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.203318	800,231	0	0	162,701	56.00
57.00	05700	CT SCAN	0.043609	5,355,464	0	0	233,546	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.292298	1,311,936	0	0	383,476	58.00
60.00	06000	LABORATORY	0.255821	2,212,275	0	0	565,946	60.00
64.00	06400	INTRAVENOUS THERAPY	0.768454	397,763	0	0	305,663	64.00
65.00	06500	RESPIRATORY THERAPY	0.626132	310,933	0	0	194,685	65.00
66.00	06600	PHYSICAL THERAPY	0.526732	36,812	0	0	19,390	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.417687	27,162	0	0	11,345	67.00
68.00	06800	SPEECH PATHOLOGY	0.406521	893	0	0	363	68.00
69.00	06900	ELECTROCARDIOLOGY	0.430150	530,461	0	0	228,178	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.509879	1,241,752	0	0	633,143	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	0.420821	4,488,924	0	222	1,889,033	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.474798	1,390,198	0	0	660,063	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.952709	151,114	0	0	143,968	76.00
76.97	07697	CARDIAC REHABILITATION	0.412310	204,328	0	0	84,246	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
91.00	09100	EMERGENCY	0.455453	2,547,218	0	110	1,160,138	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.019912	745,686	0	0	760,534	92.00
200.00		Subtotal (see instructions)		26,963,608	0	332	8,930,802	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		26,963,608	0	332	8,930,802	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part V Date/Time Prepared: 9/11/2023 9:16 am

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		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
54.02	03440	MAMMOGRAPHY	0	0		54.02
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	93		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
91.00	09100	EMERGENCY	0	50		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	143		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	143		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0210 | Component CCN: 14-S210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part II Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | Subprovider - IPF | 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	569,388	7,108,459	0.080100	0	0	50.00
53.00	05300	ANESTHESIOLOGY	11,499	2,128,735	0.005402	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,690	4,169,671	0.021030	6,632	139	54.00
54.01	05401	ULTRASOUND	34,347	4,619,753	0.007435	8,084	60	54.01
54.02	03440	MAMMOGRAPHY	10,680	530,069	0.020148	0	0	54.02
56.00	05600	RADIOISOTOPE	50,719	2,029,786	0.024987	1,247	31	56.00
57.00	05700	CT SCAN	28,422	19,895,723	0.001429	25,681	37	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	519,944	4,472,214	0.116261	0	0	58.00
60.00	06000	LABORATORY	201,875	19,159,037	0.010537	98,660	1,040	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,530,730	0.000000	5,404	0	64.00
65.00	06500	RESPIRATORY THERAPY	95,683	2,687,526	0.035603	13,575	483	65.00
66.00	06600	PHYSICAL THERAPY	98,023	1,823,555	0.053754	16,972	912	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,784	895,761	0.009806	11,689	115	67.00
68.00	06800	SPEECH PATHOLOGY	289	65,362	0.004422	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	77,657	746,832	0.103982	8,436	877	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,141	3,408,588	0.004735	202	1	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	123,308	9,235,532	0.013351	98,964	1,321	73.00
75.00	07500	ASC (NON-DISTINCT PART)	214,114	4,663,663	0.045911	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	38,940	297,964	0.130687	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	9,923	472,552	0.020999	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	328,179	2,097,813	0.156439	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	273,307	2,043,795	0.133725	0	0	88.01
91.00	09100	EMERGENCY	287,541	13,426,189	0.021416	38,621	827	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,053,350	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	3,086,453	110,562,659		334,167	5,843	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0210 | Component CCN: 14-S210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part IV | Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	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
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
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: 14-0210 | Component CCN: 14-S210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part IV | Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | Subprovider - IPF | 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	7,108,459	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,128,735	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,169,671	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	4,619,753	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	530,069	0.000000	54.02
56.00	05600	RADIOISOTOPE	0	0	0	2,029,786	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	19,895,723	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	4,472,214	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	19,159,037	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,530,730	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,687,526	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,823,555	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	895,761	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	65,362	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	746,832	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,408,588	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,235,532	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	4,663,663	0.000000	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0	0	297,964	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	472,552	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,097,813	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,043,795	0.000000	88.01
91.00	09100	EMERGENCY	0	0	0	13,426,189	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,053,350	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	110,562,659		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0210 | Component CCN: 14-S210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part IV | Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	6,632	0	212	0	54.00
54.01	05401	ULTRASOUND	0.000000	8,084	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.000000	1,247	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	25,681	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	98,660	0	121	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	5,404	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	13,575	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	16,972	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	11,689	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	8,436	0	380	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	202	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	98,964	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
91.00	09100	EMERGENCY	0.000000	38,621	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)		334,167	0	713	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0210 | Component CCN: 14-S210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part V | Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.380231	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.085130	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.442295	212	0	0	94	54.00
54.01	05401	ULTRASOUND	0.131646	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.534304	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.203318	0	0	0	0	56.00
57.00	05700	CT SCAN	0.043609	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.292298	0	0	0	0	58.00
60.00	06000	LABORATORY	0.255821	121	0	0	31	60.00
64.00	06400	INTRAVENOUS THERAPY	0.768454	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.626132	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.526732	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.417687	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.406521	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.430150	380	0	0	163	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.509879	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	0.420821	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.474798	0	0	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.952709	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.412310	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
91.00	09100	EMERGENCY	0.455453	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.019912	0	0	0	0	92.00
200.00		Subtotal (see instructions)		713	0	0	288	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		713	0	0	288	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0210 | Component CCN: 14-S210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part V | Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-1 | Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | 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)	3,227	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,112	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,828	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	76	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)	34	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	2	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)	3	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	829	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)	70	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	188.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	208.70	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,548,685	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)	377	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)	626	25.00
26.00	Total swing-bed cost (see instructions)	1,003	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,547,682	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)	7,547,682	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)	2,425.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,010,615	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)	2,010,615	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-1 | Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | 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)	2,273,518	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)	4,284,133	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)	121,482	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	133,844	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	255,326	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,028,807	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)	1,284	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,425.35	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,114,149	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-1 | Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | Hospital | PPS

	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	456,097	7,548,685	0.060421	3,114,149	188,160	90.00
91.00	Nursing Program cost	0	7,548,685	0.000000	3,114,149	0	91.00
92.00	Allied health cost	0	7,548,685	0.000000	3,114,149	0	92.00
93.00	All other Medical Education	0	7,548,685	0.000000	3,114,149	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 04/01/2022 To 03/31/2023	Worksheet D-1 Date/Time Prepared: 9/11/2023 9:16 am
	Title XVIII	Subprovider - IPF	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)	5,559	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,559	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)	5,559	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	620	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,099,385	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,099,385	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)	8,099,385	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,456.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	903,334	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)	903,334	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0210 | Component CCN: 14-S210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-1 | Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | Subprovider - IPF | 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)	120,053	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)	1,023,387	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)	53,041	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	5,843	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	58,884	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	964,503	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 04/01/2022 To 03/31/2023	Worksheet D-1 Date/Time Prepared: 9/11/2023 9:16 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description					1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	475,566	8,099,385	0.058716	0	0	90.00
91.00	Nursing Program cost	0	8,099,385	0.000000	0	0	91.00
92.00	Allied health cost	0	8,099,385	0.000000	0	0	92.00
93.00	All other Medical Education	0	8,099,385	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-3 | Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | 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		918,682		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.380231	151,669	57,669	50.00
53.00	05300	ANESTHESIOLOGY	0.085130	31,191	2,655	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.442295	98,739	43,672	54.00
54.01	05401	ULTRASOUND	0.131646	206,049	27,126	54.01
54.02	03440	MAMMOGRAPHY	0.534304	0	0	54.02
56.00	05600	RADIOISOTOPE	0.203318	22,362	4,547	56.00
57.00	05700	CT SCAN	0.043609	910,994	39,728	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.292298	116,748	34,125	58.00
60.00	06000	LABORATORY	0.255821	1,119,073	286,282	60.00
64.00	06400	INTRAVENOUS THERAPY	0.768454	203,303	156,229	64.00
65.00	06500	RESPIRATORY THERAPY	0.626132	717,762	449,414	65.00
66.00	06600	PHYSICAL THERAPY	0.526732	235,675	124,138	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.417687	188,526	78,745	67.00
68.00	06800	SPEECH PATHOLOGY	0.406521	3,114	1,266	68.00
69.00	06900	ELECTROCARDIOLOGY	0.430150	105,804	45,512	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.509879	251,761	128,368	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.420821	523,296	220,214	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.474798	6,296	2,989	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.952709	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.412310	278	115	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	0.455453	549,144	250,109	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.019912	314,356	320,615	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,756,140	2,273,518	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)		5,756,140		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0210 | Component CCN: 14-S210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-3 | Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
40.00	04000	SUBPROVIDER - IPF		859,978		40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.380231	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.085130	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.442295	6,632	2,933	54.00
54.01	05401	ULTRASOUND	0.131646	8,084	1,064	54.01
54.02	03440	MAMMOGRAPHY	0.534304	0	0	54.02
56.00	05600	RADIOISOTOPE	0.203318	1,247	254	56.00
57.00	05700	CT SCAN	0.043609	25,681	1,120	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.292298	0	0	58.00
60.00	06000	LABORATORY	0.255821	98,660	25,239	60.00
64.00	06400	INTRAVENOUS THERAPY	0.768454	5,404	4,153	64.00
65.00	06500	RESPIRATORY THERAPY	0.626132	13,575	8,500	65.00
66.00	06600	PHYSICAL THERAPY	0.526732	16,972	8,940	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.417687	11,689	4,882	67.00
68.00	06800	SPEECH PATHOLOGY	0.406521	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.430150	8,436	3,629	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.509879	202	103	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.420821	98,964	41,646	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.474798	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.952709	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.412310	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	0.455453	38,621	17,590	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.019912	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		334,167	120,053	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)		334,167		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0210 | Component CCN: 14-U210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-3 | Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
40.00	04000	SUBPROVIDER - IPF				40.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.380231	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.085130	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.442295	414	183	54.00
54.01	05401	ULTRASOUND	0.131646	570	75	54.01
54.02	03440	MAMMOGRAPHY	0.534304	0	0	54.02
56.00	05600	RADIOISOTOPE	0.203318	0	0	56.00
57.00	05700	CT SCAN	0.043609	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.292298	0	0	58.00
60.00	06000	LABORATORY	0.255821	15,183	3,884	60.00
64.00	06400	INTRAVENOUS THERAPY	0.768454	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.626132	20,756	12,996	65.00
66.00	06600	PHYSICAL THERAPY	0.526732	42,619	22,449	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.417687	36,351	15,183	67.00
68.00	06800	SPEECH PATHOLOGY	0.406521	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.430150	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.509879	7,122	3,631	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.420821	24,108	10,145	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.474798	611	290	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.952709	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.412310	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	0.455453	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.019912	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		147,734	68,836	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)		147,734		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0210	Period: From 04/01/2022 To 03/31/2023	Worksheet E Part A Date/Time Prepared: 9/11/2023 9:16 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,183,581	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	926,731	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	19,899	2.04
3.00	Managed Care Simulated Payments	797,205	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	36.17	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	8.72	30.00
31.00	Percentage of Medicaid patient days (see instructions)	13.29	31.00
32.00	Sum of lines 30 and 31	22.01	32.00
33.00	Allowable disproportionate share percentage (see instructions)	7.37	33.00
34.00	Disproportionate share adjustment (see instructions)	38,883	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet E Part A Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	7,192,008,710	6,874,403,459	35.00
35.01	Factor 3 (see instructions)	0.000070417	0.000068161	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	506,440	468,566	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	253,914	233,641	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	487,555		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	2,656,649		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	2,528,455		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		2,656,649	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		160,283	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		11,642	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
55.01	Cellular therapy acquisition cost (see instructions)		0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		2,828,574	59.00
60.00	Primary payer payments		13,607	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		2,814,967	61.00
62.00	Deductibles billed to program beneficiaries		343,992	62.00
63.00	Coinsurance billed to program beneficiaries		0	63.00
64.00	Allowable bad debts (see instructions)		124,873	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		81,167	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		106,137	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		2,552,142	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0	70.75
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		0	70.93
70.94	HRR adjustment amount (see instructions)		-712	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet E Part A | Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2022	323,985	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2023	311,414	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		18,745	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,168,084	71.00
71.01	Sequestration adjustment (see instructions)		55,441	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		3,011,779	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		100,864	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	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 inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,183,581	0	1,183,581		1,183,581	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	926,731	0		926,731	926,731	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	19,899	0		19,899	19,899	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	797,205	0	428,528	368,677	797,205	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0737	0.0737	0.0737	0.0737		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	38,883	0	21,808	17,075	38,883	11.00
11.01	Uncompensated care payments	36.00	487,555	0	253,914	233,641	487,555	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	2,656,649	0	1,459,303	1,197,346	2,656,649	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	2,656,649	0	1,459,303	1,197,346	2,656,649	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	160,283	0	89,193	71,090	160,283	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 9/11/2023 9:16 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	11,642	0	2,681	8,961	11,642	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	1,551,177	1,277,397	2,828,574	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	158,931	0	89,193	69,738	158,931	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,352	0	0	1,352	1,352	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	160,283	0	89,193	71,090	160,283	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.208864	0.243788		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			323,985		323,985	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				311,414	311,414	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,183,581	1,183,581		1,183,581	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	926,731		926,731	926,731	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	19,899		19,899	19,899	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	797,205	428,528	368,677	797,205	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0737	0.0737	0.0737		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	38,883	21,808	17,075	38,883	11.00
11.01	Uncompensated care payments	36.00	487,555	253,914	233,641	487,555	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	2,656,649	1,459,303	1,197,346	2,656,649	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	2,656,649	1,459,303	1,197,346	2,656,649	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	160,283	89,193	71,090	160,283	16.00
17.00	Special add-on payments for new technologies	54.00	11,642	2,681	8,961	11,642	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			1,551,177	1,277,397	2,828,574	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 9/11/2023 9:16 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	158,931	89,193	69,738	158,931	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,352	0	1,352	1,352	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	160,283	89,193	71,090	160,283	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	323,985	323,985		323,985	28.00
29.00	Low volume adjustment on or after October 1	70.97	311,414		311,414	311,414	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-712	-712	0	-712	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		18,745	0	18,745	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0210	Period: From 04/01/2022 To 03/31/2023	Worksheet E Part B Date/Time Prepared: 9/11/2023 9:16 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	143	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	8,930,802	2.00
3.00	OPPS or REH payments	5,350,669	3.00
4.00	Outlier payment (see instructions)	11,807	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)	143	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	332	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)	332	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)	332	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	189	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)	143	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)	5,362,476	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	843,624	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)	4,518,995	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)	4,518,995	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	4,518,995	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)	175,667	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	114,184	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	145,807	36.00
37.00	Subtotal (see instructions)	4,633,179	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)	4,633,179	40.00
40.01	Sequestration adjustment (see instructions)	81,081	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	4,616,815	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)	-64,717	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: 14-0210	Period: From 04/01/2022 To 03/31/2023	Worksheet E Part B Date/Time Prepared: 9/11/2023 9:16 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 04/01/2022 To 03/31/2023	Worksheet E Part B Date/Time Prepared: 9/11/2023 9:16 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	288	2.00
3.00	OPPS or REH payments	153	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)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	153	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	30	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)	123	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)	123	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	123	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	123	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)	123	40.00
40.01	Sequestration adjustment (see instructions)	2	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	121	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 04/01/2022 To 03/31/2023	Worksheet E Part B Date/Time Prepared: 9/11/2023 9:16 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
94.00	Total (sum of lines 91 and 93)	0	94.00
		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days		200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 9/11/2023 9:16 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,011,779		4,616,815	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)		3,011,779		4,616,815	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		100,864		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		64,717	6.02
7.00	Total Medicare program liability (see instructions)		3,112,643		4,552,098	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: 14-0210 | Component CCN: 14-S210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		622,585		121	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)		622,585		121	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		50,110		0	6.02
7.00	Total Medicare program liability (see instructions)		572,475		121	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: 14-0210 | Component CCN: 14-U210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		56,661		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)		56,661		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		56,661		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: 14-0210	Period: From 04/01/2022 To 03/31/2023	Worksheet E-1 Part II Date/Time Prepared: 9/11/2023 9:16 am
	Title XVIII	Hospital	PPS

			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: 14-0210 | Component CCN: 14-U210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet E-2 | Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | Swing Beds - SNF | PPS

		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)	61,264	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)	0	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	70	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)	61,264	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	61,264	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)	61,264	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,501	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	57,763	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)	57,763	0	19.00
19.01	Sequestration adjustment (see instructions)	1,102	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	56,661	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)	0	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: 14-0210 Component CCN: 14-S210	Period: From 04/01/2022 To 03/31/2023	Worksheet E-3 Part II Date/Time Prepared: 9/11/2023 9:16 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	619,222	1.00
2.00	Net IPF PPS Outlier Payments	1,336	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	15.230137	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	620,558	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	620,558	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	620,558	18.00
19.00	Deductibles	67,304	19.00
20.00	Subtotal (line 18 minus line 19)	553,254	20.00
21.00	Coinsurance	13,226	21.00
22.00	Subtotal (line 20 minus line 21)	540,028	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	65,606	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	42,644	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	50,774	25.00
26.00	Subtotal (sum of lines 22 and 24)	582,672	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.98	Recovery of accelerated depreciation.	0	30.98
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	582,672	31.00
31.01	Sequestration adjustment (see instructions)	10,197	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	622,585	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	-50,110	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	1,336	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)		
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 14-0210	Period: From 04/01/2022 To 03/31/2023	Worksheet E-5 Date/Time Prepared: 9/11/2023 9:16 am
	Title XVIII		PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR		
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2	0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)	0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)	0	4.00
5.00	The rate used to calculate the time value of money (see instructions)	0.00	5.00
6.00	Time value of money for operating expenses (see instructions)	0	6.00
7.00	Time value of money for capital related expenses (see instructions)	0	7.00

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

Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet G | Date/Time Prepared: 9/11/2023 9:16 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,652,284	0	0	0	1.00
2.00	Temporary investments	33,569	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	15,570,971	0	0	0	4.00
5.00	Other receivable	102,344	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,353,376	0	0	0	6.00
7.00	Inventory	1,373,336	0	0	0	7.00
8.00	Prepaid expenses	313,680	0	0	0	8.00
9.00	Other current assets	18,064	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)	11,710,872	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	772,443	0	0	0	12.00
13.00	Land improvements	154,334	0	0	0	13.00
14.00	Accumulated depreciation	-49,787	0	0	0	14.00
15.00	Buildings	20,813,541	0	0	0	15.00
16.00	Accumulated depreciation	-2,132,238	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	43,061	0	0	0	19.00
20.00	Accumulated depreciation	-1,492	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	5,049,815	0	0	0	23.00
24.00	Accumulated depreciation	-1,977,158	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	372,013	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	23,044,532	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	336,190	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	336,190	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	35,091,594	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	890,397	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,786,730	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	957,907	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	486,891				42.00
43.00	Due to other funds	1,759,780	0	0	0	43.00
44.00	Other current liabilities	805,209	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,686,914	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	17,131,379	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	207,136	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	17,338,515	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,025,429	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	10,066,165				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)	10,066,165	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	35,091,594	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet G-1 | Date/Time Prepared: 9/11/2023 9:16 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		16,235,269		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-6,276,255				2.00
3.00	Total (sum of line 1 and line 2)		9,959,014		0		3.00
4.00	PRIOR PERIOD ADJUSTMENT	107,151		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)		107,151		0		10.00
11.00	Subtotal (line 3 plus line 10)		10,066,165		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)		10,066,165		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	PRIOR PERIOD ADJUSTMENT		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: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 9/11/2023 9:16 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,997,700		1,997,700	1.00
2.00	SUBPROVIDER - IPF	7,730,325		7,730,325	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	62,370		62,370	5.00
6.00	Swing bed - NF	2,835		2,835	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	9,793,230		9,793,230	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)	9,793,230		9,793,230	17.00
18.00	Ancillary services	8,479,116	81,462,396	89,941,512	18.00
19.00	Outpatient services	1,493,327	14,986,212	16,479,539	19.00
20.00	RURAL HEALTH CLINIC	0	2,097,813	2,097,813	20.00
20.01	RURAL HEALTH CLINIC II	0	2,043,795	2,043,795	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PROFESSIONAL FEE CHARGES	921,334	2,019,044	2,940,378	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	20,687,007	102,609,260	123,296,267	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		56,086,224		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)		56,086,224		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0210 | Period: From 04/01/2022 To 03/31/2023 | Worksheet G-3 | Date/Time Prepared: 9/11/2023 9:16 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	123,296,267	1.00
2.00	Less contractual allowances and discounts on patients' accounts	74,007,862	2.00
3.00	Net patient revenues (line 1 minus line 2)	49,288,405	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	56,086,224	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,797,819	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	283,088	6.00
7.00	Income from investments	-93,173	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	897	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	67,140	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	24,539	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	5,157	21.00
22.00	Rental of hospital space	151,225	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	34,584	24.00
24.01	FOUNDATION INCOME	76,051	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	549,508	25.00
26.00	Total (line 5 plus line 25)	-6,248,311	26.00
27.00	LOSS ON DISPOSAL OF ASSETS	27,944	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	27,944	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-6,276,255	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0210	Period: From 04/01/2022 To 03/31/2023	Worksheet L Parts I-III Date/Time Prepared: 9/11/2023 9:16 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	158,931	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	1,352	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	5.01	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	160,283	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210 | Component CCN: 14-3473 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-1 | Date/Time Prepared: 9/11/2023 9:16 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	575,786	0	575,786	-51,766	524,020	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	240,741	0	240,741	-4,849	235,892	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	252,468	0	252,468	0	252,468	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,068,995	0	1,068,995	-56,615	1,012,380	10.00
11.00	Physician Services Under Agreement	0	47,789	47,789	-5	47,784	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	47,789	47,789	-5	47,784	14.00
15.00	Medical Supplies	0	1,521	1,521	35,184	36,705	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	1,521	1,521	35,184	36,705	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,068,995	49,310	1,118,305	-21,436	1,096,869	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	35,398	35,398	-35,184	214	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	56,620	56,620	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	35,398	35,398	21,436	56,834	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	77,790	77,790	-37,246	40,544	29.00
30.00	Administrative Costs	328,639	96,097	424,736	-22,770	401,966	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	328,639	173,887	502,526	-60,016	442,510	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,397,634	258,595	1,656,229	-60,016	1,596,213	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210 | Component CCN: 14-3473 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-1 | Date/Time Prepared: 9/11/2023 9:16 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	524,020		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	235,892		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	252,468		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	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,012,380		10.00
11.00	Physician Services Under Agreement	0	47,784		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	47,784		14.00
15.00	Medical Supplies	0	36,705		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	36,705		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,096,869		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	214		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	56,620		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	56,834		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	40,544		29.00
30.00	Administrative Costs	0	401,966		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	442,510		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,596,213		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210 | Component CCN: 14-8590 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-1 | Date/Time Prepared: 9/11/2023 9:16 am

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	321,069	0	321,069	0	321,069	1.00
2.00	Physician Assistant	74,310	0	74,310	-31,011	43,299	2.00
3.00	Nurse Practitioner	202,705	0	202,705	-33,887	168,818	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	158,182	0	158,182	0	158,182	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	756,266	0	756,266	-64,898	691,368	10.00
11.00	Physician Services Under Agreement	0	157,576	157,576	-6,459	151,117	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	157,576	157,576	-6,459	151,117	14.00
15.00	Medical Supplies	0	331	331	18,033	18,364	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	331	331	18,033	18,364	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	756,266	157,907	914,173	-53,324	860,849	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	21,540	21,540	-18,033	3,507	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	71,357	71,357	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	21,540	21,540	53,324	74,864	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	257,018	257,018	-223,241	33,777	29.00
30.00	Administrative Costs	277,095	188,030	465,125	-19,475	445,650	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	277,095	445,048	722,143	-242,716	479,427	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,033,361	624,495	1,657,856	-242,716	1,415,140	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210 | Component CCN: 14-8590 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-1 | Date/Time Prepared: 9/11/2023 9:16 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	321,069		1.00
2.00	Physician Assistant	0	43,299		2.00
3.00	Nurse Practitioner	0	168,818		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	158,182		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	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	691,368		10.00
11.00	Physician Services Under Agreement	0	151,117		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	151,117		14.00
15.00	Medical Supplies	0	18,364		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	18,364		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	860,849		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	3,507		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	71,357		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	74,864		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	33,777		29.00
30.00	Administrative Costs	0	445,650		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	479,427		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,415,140		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210 | Component CCN: 14-3473 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-2 | Date/Time Prepared: 9/11/2023 9:16 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.58	4,278	4,200	2,436		1.00
2.00	Physician Assistant	1.29	5,410	2,100	2,709		2.00
3.00	Nurse Practitioner	0.95	3,454	2,100	1,995		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.82	13,142		7,140	13,142	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)	2.82	13,142			13,142	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,096,869	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					56,834	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,153,703	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.950738	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					442,510	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,588,839	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,031,349	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,031,349	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,931,281	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,028,150	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210 | Component CCN: 14-8590 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-2 | Date/Time Prepared: 9/11/2023 9:16 am

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.62	1,731	4,200	2,604		1.00
2.00	Physician Assistant	0.52	2,374	2,100	1,092		2.00
3.00	Nurse Practitioner	0.97	6,044	2,100	2,037		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.11	10,149		5,733	10,149	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)	2.11	10,149			10,149	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)					860,849	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					74,864	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					935,713	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.919993	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					479,427	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,312,826	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,792,253	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,792,253	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,648,860	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,509,709	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0210 Component CCN: 14-3473	Period: From 04/01/2022 To 03/31/2023	Worksheet M-3 Date/Time Prepared: 9/11/2023 9:16 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,028,150	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			107,294	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,920,856	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			13,142	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)			13,142	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			222.25	7.00
		Calculation of Limit (1)			
		Rate Period 1 (04/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 03/31/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	203.46	211.19		8.00
9.00	Rate for Program covered visits (see instructions)	203.46	211.19		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	2,757	891		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	560,939	188,170		11.00
12.00	Program covered visits for mental health services (from contractor records)	9	1		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	1,831	211		13.00
14.00	Limit adjustment for mental health services (see instructions)	1,831	211		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	751,151		16.00
16.01	Total program charges (see instructions)(from contractor's records)		617,038		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		64,258		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		78,224		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.)		493,060		16.04
16.05	Total program cost (see instructions)	0	571,284		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		56,602		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		99,093		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		571,284		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		46,279		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		617,563		22.00
23.00	Allowable bad debts (see instructions)		36,552		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		23,759		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		31,607		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)		641,322		26.00
26.01	Sequestration adjustment (see instructions)		11,223		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		557,498		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)		72,601		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0210 Component CCN: 14-8590	Period: From 04/01/2022 To 03/31/2023	Worksheet M-3 Date/Time Prepared: 9/11/2023 9:16 am
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,509,709	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			57,768	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,451,941	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			10,149	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)			10,149	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			241.59	7.00
		Calculation of Limit (1)			
		Rate Period 1 (04/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 03/31/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	213.90	222.03		8.00
9.00	Rate for Program covered visits (see instructions)	213.90	222.03		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	1,895	439		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	405,341	97,471		11.00
12.00	Program covered visits for mental health services (from contractor records)	43	13		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	9,198	2,886		13.00
14.00	Limit adjustment for mental health services (see instructions)	9,198	2,886		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	514,896		16.00
16.01	Total program charges (see instructions)(from contractor's records)		428,251		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		28,015		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		33,683		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.)		351,319		16.04
16.05	Total program cost (see instructions)	0	385,002		16.05
17.00	Primary payer amounts		161		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		42,064		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		71,634		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		384,841		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		37,329		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		422,170		22.00
23.00	Allowable bad debts (see instructions)		21,326		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		13,862		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		19,225		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)		436,032		26.00
26.01	Sequestration adjustment (see instructions)		7,630		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		376,522		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)		51,880		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: 14-0210 | Component CCN: 14-3473 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-4 | Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,012,380	1,012,380	1,012,380	1,012,380	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000524	0.003112	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	530	3,151	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	14,151	21,033	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	14,681	24,184	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,096,869	1,096,869	1,096,869	1,096,869	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,931,281	1,931,281	1,931,281	1,931,281	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.013384	0.022048	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	25,848	42,581	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	40,529	66,765	0	0	10.00
11.00	Total number of injections/infusions (from your records)	92	546	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	440.53	122.28	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	24	292	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)	10,573	35,706	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)		107,294	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)		46,279	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0210 | Component CCN: 14-8590 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-4 | Date/Time Prepared: 9/11/2023 9:16 am

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	691,368	691,368	691,368	691,368	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000243	0.002334	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	168	1,614	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	4,247	13,786	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4,415	15,400	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	860,849	860,849	860,849	860,849	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,648,860	1,648,860	1,648,860	1,648,860	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.005129	0.017889	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	8,457	29,496	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	12,872	44,896	0	0	10.00
11.00	Total number of injections/infusions (from your records)	32	307	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	402.25	146.24	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	15	214	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)	6,034	31,295	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)		57,768	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)		37,329	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0210 Component CCN: 14-3473	Period: From 04/01/2022 To 03/31/2023	Worksheet M-5 Date/Time Prepared: 9/11/2023 9:16 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		557,498	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)		557,498	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		72,601	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		630,099	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0210 Component CCN: 14-8590	Period: From 04/01/2022 To 03/31/2023	Worksheet M-5 Date/Time Prepared: 9/11/2023 9:16 am
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		376,522	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)		376,522	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		51,880	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		428,402	7.00

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