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: 14-1308	Period: From 05/01/2022 To 04/30/2023	Worksheet S Parts I-III Date/Time Prepared: 9/13/2023 6:00 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 9/13/2023 Time: 6:00 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WASHINGTON COUNTY HOSPITAL (14-1308) for the cost reporting period beginning 05/01/2022 and ending 04/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Brian K Monsma		X	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	Brian K Monsma			2
3	Signatory Title	President			3
4	Date	9/25/2023			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	63,875	158,837	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	347,510	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC GRAND I	0		58,131		0	10.00
10.01	RURAL HEALTH CLINIC MILL ST II	0		-24,446		0	10.01
200.00	TOTAL	0	411,385	192,522	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 9/13/2023 6:00 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 705 SOUTH GRAND AVENUE	PO Box:			1.00
2.00	City: NASHVILLE	State: IL	Zip Code: 62263	County: WASHINGTON	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	WASHINGTON COUNTY HOSPITAL	141308	99914	1	12/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	WASHINGTON COUNTY SWING BED	14Z308	99914		08/18/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC	WASHINTON COUNTY EXTENDED CARE								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	GRAND STREET RHC	143472	99914		08/01/2005	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	MILL STREET RHC	148626	99914		11/23/2021	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)	05/01/2022	04/30/2023	20.00
21.00	Type of Control (see instructions)	11		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 9/13/2023 6:00 pm

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
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.				58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1308	Period: From 05/01/2022 To 04/30/2023	Worksheet S-2 Part I Date/Time Prepared: 9/13/2023 6:00 pm

		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: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 9/13/2023 6:00 pm

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 9/13/2023 6:00 pm

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

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

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

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

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

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

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	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.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 9/13/2023 6:00 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	53,857	0	0	118.01

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 9/13/2023 6:00 pm

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 9/13/2023 6:00 pm

			Y/N	Date	
			1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE				
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	07/31/2023	Y	07/31/2023 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-2 Part II Date/Time Prepared: 9/13/2023 6:00 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					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.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					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.	JENNIFER		VENABLE		41.00
42.00	Enter the employer/company name of the cost report preparer	WASHINGTON COUNTY HOSPITAL				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-327-2369		JVENABLE@WASHINGTONCOUNTYHOSPITAL.OR		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1308	Period: From 05/01/2022 To 04/30/2023	Worksheet S-2 Part II Date/Time Prepared: 9/13/2023 6:00 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CHIEF FINANCIAL OFFICER		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: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 9/13/2023 6:00 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	8,030	2,438.40	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)		22	8,030	2,438.40	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)		22	8,030	2,438.40	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	28	5,152			21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	115.00					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 GRAND	88.00				0	26.00
26.01	RURAL HEALTH CLINIC MILL ST	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		50				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: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 9/13/2023 6:00 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	72	1	123			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	785	0	835			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	2,527			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	857	1	3,485			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)	857	1	3,485	0.00	95.10	14.00
15.00	CAH visits	8,041	1,423	25,418			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			2,761	0.00	6.68	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				0.00	0.00	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 GRAND	1,959	0	8,127	0.00	10.44	26.00
26.01	RURAL HEALTH CLINIC MILL ST	223	0	1,904	0.00	1.79	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	114.01	27.00
28.00	Observation Bed Days		0	114			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: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 9/13/2023 6:00 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	24	1	48	1.00
2.00	HMO and other (see instructions)			0	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	24	1	48	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	0.00				16	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	0.00					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 GRAND	0.00					26.00
26.01	RURAL HEALTH CLINIC MILL ST	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1308 | Component CCN: 14-3472 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-8 | Date/Time Prepared: 9/13/2023 6:00 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			705 SOUTH GRAND AVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	NASHVILLE		IL	62263	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:30	17:30	07:30	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		WASHINGTON				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:30	07:30	17:30	07:30	17:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1308 | Component CCN: 14-3472 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-8 | Date/Time Prepared: 9/13/2023 6:00 pm

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:30	17:30	08:00	12:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1308 | Component CCN: 14-8626 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-8 | Date/Time Prepared: 9/13/2023 6:00 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1245 S. MILL ST.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	NASHVILLE		IL	62263	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			11:00	18:00	10:00	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		WASHINGTON			2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	10:00	17:00	10:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1308 | Component CCN: 14-8626 | Period: From 05/01/2022 To 04/30/2023 | Worksheet S-8 | Date/Time Prepared: 9/13/2023 6:00 pm

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	11:00	18:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1308	Period: From 05/01/2022 To 04/30/2023	Worksheet S-10 Date/Time Prepared: 9/13/2023 6:00 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.641341	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,762,024	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	2,041,195	6.00
7.00	Medicaid cost (line 1 times line 6)	1,309,102	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	102,598	7,414	110,012	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	65,800	7,414	73,214	21.00
22.00	Payments received from patients for amounts previously written off as charity care	260	379	639	22.00
23.00	Cost of charity care (line 21 minus line 22)	65,540	7,035	72,575	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)	326,758	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	46,901	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	72,155	27.01
28.00	Non-Medicare bad debt expense (see instructions)	254,603	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	188,541	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	261,116	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	261,116	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A | Date/Time Prepared: 9/13/2023 6:00 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		304,371	304,371	-79,168	225,203	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		323,722	323,722	0	323,722	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	26,333	1,848,199	1,874,532	0	1,874,532	4.00
5.01	00550	INFORMATION SYSTEMS	198,246	424,419	622,665	-43,171	579,494	5.01
5.02	00591	ADMITTING	181,962	9,049	191,011	0	191,011	5.02
5.03	00570	PATIENT ACCOUNTING	191,510	68,167	259,677	0	259,677	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	142,214	1,148,226	1,290,440	111,701	1,402,141	5.04
6.00	00600	MAINTENANCE & REPAIRS	157,274	503,048	660,322	-8,832	651,490	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	90,794	90,794	0	90,794	8.00
9.00	00900	HOUSEKEEPING	293,608	31,030	324,638	0	324,638	9.00
10.00	01000	DIETARY	243,173	132,493	375,666	-69,302	306,364	10.00
11.00	01100	CAFETERIA	0	0	0	69,302	69,302	11.00
13.00	01300	NURSING ADMINISTRATION	141,892	2,316	144,208	0	144,208	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,589	43,303	109,892	0	109,892	14.00
15.00	01500	PHARMACY	148,313	18,050	166,363	0	166,363	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	200,659	18,273	218,932	0	218,932	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	7,233	7,233	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	38,400	38,400	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,193,812	445,362	1,639,174	-395,319	1,243,855	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	320,161	320,161	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	156,774	60,726	217,500	0	217,500	50.00
53.00	05300	ANESTHESIOLOGY	0	42,043	42,043	-38,400	3,643	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	309,038	426,436	735,474	43,171	778,645	54.00
60.00	06000	LABORATORY	468,066	530,123	998,189	0	998,189	60.00
65.00	06500	RESPIRATORY THERAPY	4,329	25,576	29,905	0	29,905	65.00
66.00	06600	PHYSICAL THERAPY	837,066	10,727	847,793	0	847,793	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
68.01	06801	CARDIAC REHAB	77,664	14,751	92,415	0	92,415	68.01
69.00	06900	ELECTROCARDIOLOGY	5,844	7,872	13,716	0	13,716	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	34,714	34,714	-11,970	22,744	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,970	11,970	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	976,069	976,069	0	976,069	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	1,105,356	235,225	1,340,581	-53,857	1,286,724	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	144,928	36,580	181,508	34,448	215,956	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	449,146	1,419,296	1,868,442	0	1,868,442	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OP SVCS	0	0	0	67,925	67,925	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		4,292	4,292	-4,292	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,743,796	9,235,252	15,979,048	0	15,979,048	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,660	4,660	0	4,660	190.00
190.01	19001	OUTPATIENT CLINIC	0	4,454	4,454	0	4,454	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	6,743,796	9,244,366	15,988,162	0	15,988,162	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A | Date/Time Prepared: 9/13/2023 6:00 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	29,853	255,056		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	77,515	401,237		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,874,532		4.00
5.01	00550	INFORMATION SYSTEMS	-5,296	574,198		5.01
5.02	00591	ADMITTING	0	191,011		5.02
5.03	00570	PATIENT ACCOUNTING	0	259,677		5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	1,641,235	3,043,376		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	651,490		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	90,794		8.00
9.00	00900	HOUSEKEEPING	0	324,638		9.00
10.00	01000	DIETARY	0	306,364		10.00
11.00	01100	CAFETERIA	-9,650	59,652		11.00
13.00	01300	NURSING ADMINISTRATION	0	144,208		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	109,892		14.00
15.00	01500	PHARMACY	0	166,363		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,949	214,983		16.00
17.00	01700	SOCIAL SERVICE	0	7,233		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	38,400		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,243,855		30.00
46.00	04600	OTHER LONG TERM CARE	0	320,161		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	217,500		50.00
53.00	05300	ANESTHESIOLOGY	0	3,643		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,731	773,914		54.00
60.00	06000	LABORATORY	0	998,189		60.00
65.00	06500	RESPIRATORY THERAPY	-316	29,589		65.00
66.00	06600	PHYSICAL THERAPY	0	847,793		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	CARDIAC REHAB	0	92,415		68.01
69.00	06900	ELECTROCARDIOLOGY	-7,291	6,425		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,744		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,970		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-100,915	875,154		73.00
76.00	03480	ONCOLOGY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC GRAND	-207,999	1,078,725		88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	0	215,956		88.01
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-150,890	1,717,552		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04950	OTHER OP SVCS	0	67,925		93.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,257,566	17,236,614		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,660		190.00
190.01	19001	OUTPATIENT CLINIC	0	4,454		190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0		190.02
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	MILL STREET CLINIC	0	0		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	1,257,566	17,245,728		200.00

RECLASSIFICATIONS | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-6 | Date/Time Prepared: 9/13/2023 6:00 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASSIFY CAFETERIA COSTS					
1.00	CAFETERIA	11.00	44,860	24,442		1.00
	TOTALS		44,860	24,442		
	B - RECLASS SOCIAL SERVICE COST					
1.00	SOCIAL SERVICE	17.00	7,233	0		1.00
	TOTALS		7,233	0		
	C - RECLASS PROFESSIONAL LIABILITY INSUR					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	53,857		1.00
	TOTALS		0	53,857		
	D - RECLASSIFY XRAY DIRECTORS SALARY					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	43,171	0		1.00
	TOTALS		43,171	0		
	E - RECLASSIFY ANESTHESIA PRO FEES					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	38,400		1.00
	TOTALS		0	38,400		
	F - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,292		1.00
	TOTALS		0	4,292		
	G - TO RECLASS INTEROCULAR LENS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	11,970		1.00
	TOTALS		0	11,970		
	H - MILL STREET CLINIC EXPENSES					
1.00	RURAL HEALTH CLINIC MILL ST	88.01	0	83,460		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	57,844		2.00
3.00	RURAL HEALTH CLINIC MILL ST	88.01	5,793	3,039		3.00
	TOTALS		5,793	144,343		
	I - RESTORIX (WOUND CARE)					
1.00	OTHER OP SVCS	93.00	0	67,925		1.00
	TOTALS		0	67,925		
	K - SUPPORTIVE CARE					
1.00	OTHER LONG TERM CARE	46.00	303,845	16,316		1.00
	TOTALS		303,845	16,316		
500.00	Grand Total: Increases		404,902	361,545		500.00

RECLASSIFICATIONS | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-6 | Date/Time Prepared: 9/13/2023 6:00 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASSIFY CAFETERIA COSTS						
1.00	DIETARY	10.00	44,860	24,442	0		1.00
	TOTALS		44,860	24,442			
	B - RECLASS SOCIAL SERVICE COST						
1.00	ADULTS & PEDIATRICS	30.00	7,233	0	0		1.00
	TOTALS		7,233	0			
	C - RECLASS PROFESSIONAL LIABILITY INSUR						
1.00	RURAL HEALTH CLINIC GRAND	88.00	0	53,857	0		1.00
	TOTALS		0	53,857			
	D - RECLASSIFY XRAY DIRECTORS SALARY						
1.00	INFORMATION SYSTEMS	5.01	43,171	0	0		1.00
	TOTALS		43,171	0			
	E - RECLASSIFY ANESTHESIA PRO FEES						
1.00	ANESTHESIOLOGY	53.00	0	38,400	0		1.00
	TOTALS		0	38,400			
	F - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	4,292	11		1.00
	TOTALS		0	4,292			
	G - TO RECLASS INTEROCULAR LENS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	11,970	0		1.00
	TOTALS		0	11,970			
	H - MILL STREET CLINIC EXPENSES						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	83,460	9		1.00
2.00	RURAL HEALTH CLINIC MILL ST	88.01	0	57,844	0		2.00
3.00	MAINTENANCE & REPAIRS	6.00	5,793	3,039	0		3.00
	TOTALS		5,793	144,343			
	I - RESTORIX (WOUND CARE)						
1.00	ADULTS & PEDIATRICS	30.00	0	67,925	0		1.00
	TOTALS		0	67,925			
	K - SUPPORTIVE CARE						
1.00	ADULTS & PEDIATRICS	30.00	303,845	16,316	0		1.00
	TOTALS		303,845	16,316			
500.00	Grand Total: Decreases		404,902	361,545			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 9/13/2023 6:00 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	62,855	0	0	0	0	1.00
2.00	Land Improvements	419,030	0	0	0	0	2.00
3.00	Buildings and Fixtures	9,800,211	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	6,673,299	120,326	0	120,326	259,776	6.00
7.00	HIT designated Assets	927,041	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	17,882,436	120,326	0	120,326	259,776	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	17,882,436	120,326	0	120,326	259,776	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	62,855	0	1.00
2.00	Land Improvements	419,030	0	2.00
3.00	Buildings and Fixtures	9,800,211	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	6,533,849	0	6.00
7.00	HIT designated Assets	927,041	0	7.00
8.00	Subtotal (sum of lines 1-7)	17,742,986	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	17,742,986	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 9/13/2023 6:00 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	304,371	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	323,722	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	628,093	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	304,371		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	323,722		2.00
3.00	Total (sum of lines 1-2)	0	628,093		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 9/13/2023 6:00 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	10,282,095	0	10,282,095	0.579502	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,460,891	0	7,460,891	0.420498	0	2.00
3.00	Total (sum of lines 1-2)	17,742,986	0	17,742,986	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	255,056	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	401,237	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	656,293	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	255,056	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	401,237	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	656,293	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-8 | Date/Time Prepared: 9/13/2023 6:00 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
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)	B	-4,292	CAP REL COSTS-BLDG & FIXT	1.00	11	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	0	CENTRAL SERVICES & SUPPLY	14.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-163,174			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-54	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,764,276			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-9,650	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-3,949	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	MISCELLANEOUS REVENUE - OTHER	B	-1,012	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-8 | Date/Time Prepared: 9/13/2023 6:00 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.00
35.00	EDUCATION FEES	B	0	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	35.00
36.00	NONALLOWABLE PUBLIC RELATIONS	A	-12,800	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	36.00
37.00	HEALTHLINK ADMIN FEES	A	12,118	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	37.00
38.00	LOBBYING PORTION OF DUES	A	-9,687	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	38.00
39.00	NON-RHC SERVICES	A	-194,160	RURAL HEALTH CLINIC GRAND	88.00	0	39.00
40.00	NON-RHC BENEFITS	A	-13,839	RURAL HEALTH CLINIC GRAND	88.00	0	40.00
41.00	TELEPHONE SERVICE	A	-5,296	INFORMATION SYSTEMS	5.01	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	42.00
43.00	340B PHARMACY	A	-100,915	DRUGS CHARGED TO PATIENTS	73.00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,257,566				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: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 9/13/2023 6:00 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.04	OTHER ADMINISTRATIVE AND GEN		2,460,867	808,251	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT		34,145	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP		77,515	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.			2,572,527	808,251	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	SSM HEALTHCARE	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: 14-1308	Period: From 05/01/2022 To 04/30/2023	Worksheet A-8-1 Date/Time Prepared: 9/13/2023 6:00 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,652,616	0		1.00
2.00	34,145	9		2.00
3.00	77,515	9		3.00
4.00	0	0		4.00
5.00	1,764,276			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	HEALTHCARE		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: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 9/13/2023 6:00 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	54.00	RADIOLOGY-DIAGNOSTIC	4,677	4,677	0	0	0	1.00
2.00	60.00	LABORATORY	16,467	0	16,467	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	316	316	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	7,291	7,291	0	0	0	4.00
5.00	91.00	EMERGENCY	998,993	150,890	848,103	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,027,744	163,174	864,570		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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	4,677		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	316		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	7,291		4.00
5.00	91.00	EMERGENCY	0	0	0	150,890		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	163,174		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part I Date/Time Prepared: 9/13/2023 6:00 pm

		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	INFORMATION SYSTEMS	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	255,056	255,056				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	401,237		401,237			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,874,532	650	0	1,875,182		4.00
5.01	00550	INFORMATION SYSTEMS	574,198	4,537	168,044	43,289	790,068	5.01
5.02	00591	ADMITTING	191,011	1,960	0	50,795	30,623	5.02
5.03	00570	PATIENT ACCOUNTING	259,677	4,576	0	53,460	61,246	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	3,043,376	19,082	312	39,699	48,996	5.04
6.00	00600	MAINTENANCE & REPAIRS	651,490	41,578	50,351	42,286	30,623	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	90,794	2,953	0	0	0	8.00
9.00	00900	HOUSEKEEPING	324,638	1,931	0	81,961	12,249	9.00
10.00	01000	DIETARY	306,364	11,807	656	55,359	18,374	10.00
11.00	01100	CAFETERIA	59,652	3,584	0	12,523	0	11.00
13.00	01300	NURSING ADMINISTRATION	144,208	1,980	0	39,609	30,623	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	109,892	3,936	0	18,588	24,498	14.00
15.00	01500	PHARMACY	166,363	4,278	18,696	41,402	18,374	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	214,983	4,811	0	56,014	30,623	16.00
17.00	01700	SOCIAL SERVICE	7,233	411	0	2,019	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	38,400	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,243,855	36,398	14,870	246,415	42,872	30.00
46.00	04600	OTHER LONG TERM CARE	320,161	13,973	1,268	84,818	6,125	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	217,500	16,256	7,267	43,763	24,498	50.00
53.00	05300	ANESTHESIOLOGY	3,643	0	10,539	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	773,914	14,765	61,948	98,319	73,495	54.00
60.00	06000	LABORATORY	998,189	8,433	42,990	130,661	30,623	60.00
65.00	06500	RESPIRATORY THERAPY	29,589	484	821	1,208	0	65.00
66.00	06600	PHYSICAL THERAPY	847,793	12,447	3,062	233,667	97,993	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
68.01	06801	CARDIAC REHAB	92,415	1,985	1,210	21,680	12,249	68.01
69.00	06900	ELECTROCARDIOLOGY	6,425	235	0	1,631	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,744	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,970	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	875,154	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	1,078,725	17,786	13,926	308,563	104,116	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	215,956	0	0	42,074	18,374	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,717,552	14,100	5,277	125,379	36,747	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OP SVCS	67,925	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,236,614	244,936	401,237	1,875,182	753,321	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,660	587	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	4,454	9,533	0	0	36,747	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,245,728	255,056	401,237	1,875,182	790,068	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part I | Date/Time Prepared: 9/13/2023 6:00 pm

		Cost Center Description	ADMITTING	PATIENT ACCOUNTING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	ADMITTING	274,389					5.02
5.03	00570	PATIENT ACCOUNTING	0	378,959				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	0	3,151,465	3,151,465		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	816,328	182,530	998,858	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	93,747	20,962	16,147	8.00
9.00	00900	HOUSEKEEPING	0	0	420,779	94,086	10,560	9.00
10.00	01000	DIETARY	0	0	392,560	87,776	64,561	10.00
11.00	01100	CAFETERIA	0	0	75,759	16,940	19,595	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	216,420	48,391	10,827	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	156,914	35,086	21,520	14.00
15.00	01500	PHARMACY	0	0	249,113	55,701	23,392	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	306,431	68,518	26,305	16.00
17.00	01700	SOCIAL SERVICE	0	0	9,663	2,161	2,246	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	38,400	8,586	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,642	28,509	1,633,561	365,263	199,027	30.00
46.00	04600	OTHER LONG TERM CARE	5,335	7,368	439,048	98,171	76,403	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,333	10,128	326,745	73,060	88,888	50.00
53.00	05300	ANESTHESIOLOGY	570	787	15,539	3,475	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	74,027	102,231	1,198,699	268,028	80,734	54.00
60.00	06000	LABORATORY	59,831	82,635	1,353,362	302,610	46,115	60.00
65.00	06500	RESPIRATORY THERAPY	908	1,254	34,264	7,661	2,647	65.00
66.00	06600	PHYSICAL THERAPY	36,474	50,376	1,281,812	286,612	68,063	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
68.01	06801	CARDIAC REHAB	1,895	2,618	134,052	29,974	10,854	68.01
69.00	06900	ELECTROCARDIOLOGY	2,452	3,387	14,130	3,159	1,283	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	795	1,098	24,637	5,509	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	292	404	12,666	2,832	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,356	28,114	923,624	206,521	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	20,414	28,195	1,571,725	351,436	97,255	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	4,424	6,109	286,937	64,159	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	18,641	25,746	1,943,442	434,553	77,098	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	04950	OTHER OP SVCS	0	0	67,925	15,188	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	274,389	378,959	17,189,747	3,138,948	943,520	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	5,247	1,173	3,208	190.00
190.01	19001	OUTPATIENT CLINIC	0	0	50,734	11,344	52,130	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	274,389	378,959	17,245,728	3,151,465	998,858	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part I | Date/Time Prepared: 9/13/2023 6:00 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	ADMITTING						5.02
5.03	00570	PATIENT ACCOUNTING						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	130,856					8.00
9.00	00900	HOUSEKEEPING	0	525,425				9.00
10.00	01000	DIETARY	0	34,893	579,790			10.00
11.00	01100	CAFETERIA	0	10,591	0	122,885		11.00
13.00	01300	NURSING ADMINISTRATION	0	5,852	0	2,672	284,162	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,631	0	2,593	0	14.00
15.00	01500	PHARMACY	0	12,643	0	1,739	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,217	0	5,961	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,214	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	62,830	107,570	330,046	24,713	129,614	30.00
46.00	04600	OTHER LONG TERM CARE	37,143	41,294	233,515	10,562	62,221	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	241	48,042	0	3,036	15,187	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,008	43,635	0	7,921	0	54.00
60.00	06000	LABORATORY	216	24,924	0	12,380	0	60.00
65.00	06500	RESPIRATORY THERAPY	58	1,430	0	79	529	65.00
66.00	06600	PHYSICAL THERAPY	12,420	36,786	0	19,100	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
68.01	06801	CARDIAC REHAB	0	5,866	0	1,708	10,056	68.01
69.00	06900	ELECTROCARDIOLOGY	0	694	0	0	3,464	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	524	52,564	0	16,507	0	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	9,726	41,670	0	13,914	63,091	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OP SVCS	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	130,166	495,516	563,561	122,885	284,162	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,734	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	690	28,175	0	0	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	16,229	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	130,856	525,425	579,790	122,885	284,162	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part I | Date/Time Prepared: 9/13/2023 6:00 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			14.00	15.00	16.00	17.00	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
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	ADMITTING						5.02
5.03	00570	PATIENT ACCOUNTING						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	227,744					14.00
15.00	01500	PHARMACY	4,350	346,938				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,854	0	423,286			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	15,284		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	46,986	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,031	324	41,178	14,520	0	30.00
46.00	04600	OTHER LONG TERM CARE	8,063	0	0	764	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,832	1	15,090	0	0	50.00
53.00	05300	ANESTHESIOLOGY	143	0	0	0	46,986	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,548	469	31,459	0	0	54.00
60.00	06000	LABORATORY	0	182	58,569	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	28,557	0	256	0	0	65.00
66.00	06600	PHYSICAL THERAPY	7,743	306	38,109	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
68.01	06801	CARDIAC REHAB	2,952	0	9,207	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	705	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,597	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,524	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	345,382	0	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	12,484	42	110,233	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	11,104	0	28,390	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	25,806	232	90,795	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OP SVCS	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	227,293	346,938	423,286	15,284	46,986	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	451	0	0	0	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	227,744	346,938	423,286	15,284	46,986	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part I | Date/Time Prepared: 9/13/2023 6:00 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	INFORMATION SYSTEMS					5.01
5.02	00591	ADMITTING					5.02
5.03	00570	PATIENT ACCOUNTING					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,951,677	-92,047	2,859,630		30.00
46.00	04600	OTHER LONG TERM CARE	1,007,184	0	1,007,184		46.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	582,122	0	582,122		50.00
53.00	05300	ANESTHESIOLOGY	66,143	0	66,143		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,664,501	0	1,664,501		54.00
60.00	06000	LABORATORY	1,798,358	0	1,798,358		60.00
65.00	06500	RESPIRATORY THERAPY	75,481	0	75,481		65.00
66.00	06600	PHYSICAL THERAPY	1,750,951	0	1,750,951		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
68.01	06801	CARDIAC REHAB	204,669	0	204,669		68.01
69.00	06900	ELECTROCARDIOLOGY	23,435	0	23,435		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,743	0	57,743		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,022	0	30,022		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,475,527	0	1,475,527		73.00
76.00	03480	ONCOLOGY	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC GRAND	2,212,770	0	2,212,770		88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	390,590	0	390,590		88.01
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	2,700,327	0	2,700,327		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
93.00	04950	OTHER OP SVCS	83,113	92,047	175,160		93.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,074,613	0	17,074,613		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,362	0	11,362		190.00
190.01	19001	OUTPATIENT CLINIC	143,524	0	143,524		190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	16,229	0	16,229		190.02
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	MILL STREET CLINIC	0	0	0		194.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	17,245,728	0	17,245,728		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part II | Date/Time Prepared: 9/13/2023 6:00 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	650	0	650	650	4.00
5.01	00550	INFORMATION SYSTEMS	0	4,537	168,044	172,581	15	5.01
5.02	00591	ADMITTING	0	1,960	0	1,960	18	5.02
5.03	00570	PATIENT ACCOUNTING	0	4,576	0	4,576	19	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	19,082	312	19,394	14	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	41,578	50,351	91,929	15	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,953	0	2,953	0	8.00
9.00	00900	HOUSEKEEPING	0	1,931	0	1,931	28	9.00
10.00	01000	DIETARY	0	11,807	656	12,463	19	10.00
11.00	01100	CAFETERIA	0	3,584	0	3,584	4	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,980	0	1,980	14	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,936	0	3,936	6	14.00
15.00	01500	PHARMACY	0	4,278	18,696	22,974	14	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,811	0	4,811	19	16.00
17.00	01700	SOCIAL SERVICE	0	411	0	411	1	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	36,398	14,870	51,268	86	30.00
46.00	04600	OTHER LONG TERM CARE	0	13,973	1,268	15,241	29	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	16,256	7,267	23,523	15	50.00
53.00	05300	ANESTHESIOLOGY	0	0	10,539	10,539	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,765	61,948	76,713	34	54.00
60.00	06000	LABORATORY	0	8,433	42,990	51,423	45	60.00
65.00	06500	RESPIRATORY THERAPY	0	484	821	1,305	0	65.00
66.00	06600	PHYSICAL THERAPY	0	12,447	3,062	15,509	81	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
68.01	06801	CARDIAC REHAB	0	1,985	1,210	3,195	8	68.01
69.00	06900	ELECTROCARDIOLOGY	0	235	0	235	1	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	0	17,786	13,926	31,712	106	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	0	0	0	0	15	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	14,100	5,277	19,377	44	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04950	OTHER OP SVCS	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	244,936	401,237	646,173	650	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	587	0	587	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	9,533	0	9,533	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	255,056	401,237	656,293	650	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part II | Date/Time Prepared: 9/13/2023 6:00 pm

		Cost Center Description	INFORMATION SYSTEMS	ADMITTING	PATIENT ACCOUNTING	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.01	5.02	5.03	5.04	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS	172,596					5.01
5.02	00591	ADMITTING	6,690	8,668				5.02
5.03	00570	PATIENT ACCOUNTING	13,380	0	17,975			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	10,704	0	0	30,112		5.04
6.00	00600	MAINTENANCE & REPAIRS	6,690	0	0	1,744	100,378	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	200	1,623	8.00
9.00	00900	HOUSEKEEPING	2,676	0	0	899	1,061	9.00
10.00	01000	DIETARY	4,014	0	0	839	6,488	10.00
11.00	01100	CAFETERIA	0	0	0	162	1,969	11.00
13.00	01300	NURSING ADMINISTRATION	6,690	0	0	462	1,088	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,352	0	0	335	2,163	14.00
15.00	01500	PHARMACY	4,014	0	0	532	2,351	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,690	0	0	655	2,644	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	21	226	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	82	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,366	653	1,352	3,489	19,999	30.00
46.00	04600	OTHER LONG TERM CARE	1,338	169	349	938	7,678	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,352	232	480	698	8,933	50.00
53.00	05300	ANESTHESIOLOGY	0	18	37	33	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,055	2,328	4,853	2,560	8,113	54.00
60.00	06000	LABORATORY	6,690	1,893	3,919	2,891	4,634	60.00
65.00	06500	RESPIRATORY THERAPY	0	29	59	73	266	65.00
66.00	06600	PHYSICAL THERAPY	21,407	1,154	2,389	2,738	6,840	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
68.01	06801	CARDIAC REHAB	2,676	60	124	286	1,091	68.01
69.00	06900	ELECTROCARDIOLOGY	0	78	161	30	129	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	25	52	53	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9	19	27	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	644	1,333	1,973	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	22,742	646	1,337	3,357	9,773	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	4,014	140	290	613	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	8,028	590	1,221	4,158	7,748	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OP SVCS	0	0	0	145	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	164,568	8,668	17,975	29,993	94,817	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	11	322	190.00
190.01	19001	OUTPATIENT CLINIC	8,028	0	0	108	5,239	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	172,596	8,668	17,975	30,112	100,378	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part II | Date/Time Prepared: 9/13/2023 6:00 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	ADMITTING						5.02
5.03	00570	PATIENT ACCOUNTING						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,776					8.00
9.00	00900	HOUSEKEEPING	0	6,595				9.00
10.00	01000	DIETARY	0	438	24,261			10.00
11.00	01100	CAFETERIA	0	133	0	5,852		11.00
13.00	01300	NURSING ADMINISTRATION	0	73	0	127	10,434	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	146	0	123	0	14.00
15.00	01500	PHARMACY	0	159	0	83	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	178	0	284	0	16.00
17.00	01700	SOCIAL SERVICE	0	15	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,293	1,349	13,811	1,176	4,759	30.00
46.00	04600	OTHER LONG TERM CARE	1,356	518	9,771	503	2,285	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9	603	0	145	558	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	256	548	0	377	0	54.00
60.00	06000	LABORATORY	8	313	0	590	0	60.00
65.00	06500	RESPIRATORY THERAPY	2	18	0	4	19	65.00
66.00	06600	PHYSICAL THERAPY	453	462	0	910	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
68.01	06801	CARDIAC REHAB	0	74	0	81	369	68.01
69.00	06900	ELECTROCARDIOLOGY	0	9	0	0	127	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	19	660	0	786	0	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	355	523	0	663	2,317	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OP SVCS	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,751	6,219	23,582	5,852	10,434	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	25	354	0	0	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	679	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,776	6,595	24,261	5,852	10,434	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part II | Date/Time Prepared: 9/13/2023 6:00 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			14.00	15.00	16.00	17.00	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
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	ADMITTING						5.02
5.03	00570	PATIENT ACCOUNTING						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	12,061					14.00
15.00	01500	PHARMACY	230	30,357				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	98	0	15,379			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	674		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	82	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,279	28	1,496	640		30.00
46.00	04600	OTHER LONG TERM CARE	427	0	0	34		46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	627	0	548	0		50.00
53.00	05300	ANESTHESIOLOGY	8	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,406	41	1,143	0		54.00
60.00	06000	LABORATORY	0	16	2,128	0		60.00
65.00	06500	RESPIRATORY THERAPY	1,512	0	9	0		65.00
66.00	06600	PHYSICAL THERAPY	410	27	1,385	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
68.01	06801	CARDIAC REHAB	156	0	335	0		68.01
69.00	06900	ELECTROCARDIOLOGY	37	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,462	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	769	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	30,221	0	0		73.00
76.00	03480	ONCOLOGY	0	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	661	4	4,005	0		88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	588	0	1,031	0		88.01
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	1,367	20	3,299	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OP SVCS	0	0	0	0		93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0		115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,037	30,357	15,379	674	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
190.01	19001	OUTPATIENT CLINIC	24	0	0	0		190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0		190.02
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	MILL STREET CLINIC	0	0	0	0		194.00
200.00		Cross Foot Adjustments					82	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	12,061	30,357	15,379	674	82	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B Part II | Date/Time Prepared: 9/13/2023 6:00 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	INFORMATION SYSTEMS					5.01
5.02	00591	ADMITTING					5.02
5.03	00570	PATIENT ACCOUNTING					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	114,044	0	114,044		30.00
46.00	04600	OTHER LONG TERM CARE	40,636	0	40,636		46.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	41,723	0	41,723		50.00
53.00	05300	ANESTHESIOLOGY	10,635	0	10,635		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	114,427	0	114,427		54.00
60.00	06000	LABORATORY	74,550	0	74,550		60.00
65.00	06500	RESPIRATORY THERAPY	3,296	0	3,296		65.00
66.00	06600	PHYSICAL THERAPY	53,765	0	53,765		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
68.01	06801	CARDIAC REHAB	8,455	0	8,455		68.01
69.00	06900	ELECTROCARDIOLOGY	807	0	807		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,592	0	1,592		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	824	0	824		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,171	0	34,171		73.00
76.00	03480	ONCOLOGY	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC GRAND	75,808	0	75,808		88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	6,691	0	6,691		88.01
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	49,710	0	49,710		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
93.00	04950	OTHER OP SVCS	145	0	145		93.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	631,279	0	631,279		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	942	0	942		190.00
190.01	19001	OUTPATIENT CLINIC	23,311	0	23,311		190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	679	0	679		190.02
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	MILL STREET CLINIC	0	0	0		194.00
200.00		Cross Foot Adjustments	82	0	82		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	656,293	0	656,293		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/13/2023 6:00 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	INFORMATION SYSTEMS (# OF COMPUTERS)	ADMITTING (GROSS REVENUES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	52,170					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		294,192				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	133	0	6,717,463			4.00
5.01	00550	INFORMATION SYSTEMS	928	123,212	155,075	129		5.01
5.02	00591	ADMITTING	401	0	181,962	5	26,623,295	5.02
5.03	00570	PATIENT ACCOUNTING	936	0	191,510	10	0	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	3,903	229	142,214	8	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	8,505	36,918	151,481	5	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	604	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	395	0	293,608	2	0	9.00
10.00	01000	DIETARY	2,415	481	198,313	3	0	10.00
11.00	01100	CAFETERIA	733	0	44,860	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	405	0	141,892	5	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	805	0	66,589	4	0	14.00
15.00	01500	PHARMACY	875	13,708	148,313	3	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	984	0	200,659	5	0	16.00
17.00	01700	SOCIAL SERVICE	84	0	7,233	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,445	10,903	882,734	7	2,002,865	30.00
46.00	04600	OTHER LONG TERM CARE	2,858	930	303,845	1	517,638	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,325	5,328	156,774	4	711,558	50.00
53.00	05300	ANESTHESIOLOGY	0	7,727	0	0	55,325	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,020	45,421	352,209	12	7,182,072	54.00
60.00	06000	LABORATORY	1,725	31,521	468,066	5	5,805,455	60.00
65.00	06500	RESPIRATORY THERAPY	99	602	4,329	0	88,077	65.00
66.00	06600	PHYSICAL THERAPY	2,546	2,245	837,066	16	3,539,118	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
68.01	06801	CARDIAC REHAB	406	887	77,664	2	183,893	68.01
69.00	06900	ELECTROCARDIOLOGY	48	0	5,844	0	237,930	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	77,123	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	28,362	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,975,116	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	3,638	10,211	1,105,356	17	1,980,788	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	0	0	150,721	3	429,217	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,884	3,869	449,146	6	1,808,758	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OP SVCS	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,100	294,192	6,717,463	123	26,623,295	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	120	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	1,950	0	0	6	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	255,056	401,237	1,875,182	790,068	274,389	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.888940	1.363861	0.279150	6,124.558140	0.010306	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			650	172,596	8,668	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000097	1,337.953488	0.000326	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: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/13/2023 6:00 pm

		Cost Center Description	PATIENT ACCOUNTING (GROSS REVENUES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5.03	5A.04	5.04	6.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	ADMITTING						5.02
5.03	00570	PATIENT ACCOUNTING	26,623,295					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	-3,151,465	14,094,263			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	816,328	37,364		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	93,747	604	15,741	8.00
9.00	00900	HOUSEKEEPING	0	0	420,779	395	0	9.00
10.00	01000	DIETARY	0	0	392,560	2,415	0	10.00
11.00	01100	CAFETERIA	0	0	75,759	733	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	216,420	405	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	156,914	805	0	14.00
15.00	01500	PHARMACY	0	0	249,113	875	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	306,431	984	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	9,663	84	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	38,400	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,002,865	0	1,633,561	7,445	7,558	30.00
46.00	04600	OTHER LONG TERM CARE	517,638	0	439,048	2,858	4,468	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	711,558	0	326,745	3,325	29	50.00
53.00	05300	ANESTHESIOLOGY	55,325	0	15,539	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,182,072	0	1,198,699	3,020	843	54.00
60.00	06000	LABORATORY	5,805,455	0	1,353,362	1,725	26	60.00
65.00	06500	RESPIRATORY THERAPY	88,077	0	34,264	99	7	65.00
66.00	06600	PHYSICAL THERAPY	3,539,118	0	1,281,812	2,546	1,494	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
68.01	06801	CARDIAC REHAB	183,893	0	134,052	406	0	68.01
69.00	06900	ELECTROCARDIOLOGY	237,930	0	14,130	48	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	77,123	0	24,637	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,362	0	12,666	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,975,116	0	923,624	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	1,980,788	0	1,571,725	3,638	63	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	429,217	0	286,937	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,808,758	0	1,943,442	2,884	1,170	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OP SVCS	0	0	67,925	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,623,295	-3,151,465	14,038,282	35,294	15,658	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	5,247	120	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	0	50,734	1,950	83	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	378,959		3,151,465	998,858	130,856	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.014234		0.223599	26.733166	8.313068	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	17,975		30,112	100,378	4,776	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000675		0.002136	2.686490	0.303411	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: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/13/2023 6:00 pm

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	ADMITTING						5.02
5.03	00570	PATIENT ACCOUNTING						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	36,365					9.00
10.00	01000	DIETARY	2,415	19,292				10.00
11.00	01100	CAFETERIA	733	0	7,772			11.00
13.00	01300	NURSING ADMINISTRATION	405	0	169	63,412		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	805	0	164	0	187,694	14.00
15.00	01500	PHARMACY	875	0	110	0	3,585	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	984	0	377	0	1,528	16.00
17.00	01700	SOCIAL SERVICE	84	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,445	10,982	1,563	28,924	35,464	30.00
46.00	04600	OTHER LONG TERM CARE	2,858	7,770	668	13,885	6,645	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,325	0	192	3,389	9,751	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	118	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,020	0	501	0	21,879	54.00
60.00	06000	LABORATORY	1,725	0	783	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	99	0	5	118	23,535	65.00
66.00	06600	PHYSICAL THERAPY	2,546	0	1,208	0	6,381	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
68.01	06801	CARDIAC REHAB	406	0	108	2,244	2,433	68.01
69.00	06900	ELECTROCARDIOLOGY	48	0	0	773	581	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	22,744	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	11,970	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	3,638	0	1,044	0	10,289	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	0	0	0	0	9,151	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,884	0	880	14,079	21,268	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OP SVCS	0	0	0	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,295	18,752	7,772	63,412	187,322	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	120	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	1,950	0	0	0	372	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	540	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MILL STREET CLINIC	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	525,425	579,790	122,885	284,162	227,744	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.448646	30.053390	15.811245	4.481202	1.213379	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,595	24,261	5,852	10,434	12,061	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.181356	1.257568	0.752959	0.164543	0.064259	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: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-1 | Date/Time Prepared: 9/13/2023 6:00 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			15.00	16.00	17.00	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
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	ADMITTING						5.02
5.03	00570	PATIENT ACCOUNTING						5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	875,178					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,655				16.00
17.00	01700	SOCIAL SERVICE	0	0	100			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	818	161	95	0		30.00
46.00	04600	OTHER LONG TERM CARE	0	0	5	0		46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2	59	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,183	123	0	0		54.00
60.00	06000	LABORATORY	460	229	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	1	0	0		65.00
66.00	06600	PHYSICAL THERAPY	773	149	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
68.01	06801	CARDIAC REHAB	0	36	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	871,252	0	0	0		73.00
76.00	03480	ONCOLOGY	0	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	105	431	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	0	111	0	0		88.01
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	585	355	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OP SVCS	0	0	0	0		93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0		115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	875,178	1,655	100	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
190.01	19001	OUTPATIENT CLINIC	0	0	0	0		190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0		190.02
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	MILL STREET CLINIC	0	0	0	0		194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	346,938	423,286	15,284	46,986		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.396420	255.761934	152.840000	469.860000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	30,357	15,379	674	82		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.034687	9.292447	6.740000	0.820000		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: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet B-2 | Date/Time Prepared: 9/13/2023 6:00 pm

		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 AND PEDIATRICS	1	30.00	-92,047	7.00
8.00		OTHER OUTPATIENT SERVICES	1	93.00	92,047	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet C Part I Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,859,630		2,859,630	0	0	30.00
46.00	04600	OTHER LONG TERM CARE	1,007,184		1,007,184	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	582,122		582,122	0	0	50.00
53.00	05300	ANESTHESIOLOGY	66,143		66,143	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,664,501		1,664,501	0	0	54.00
60.00	06000	LABORATORY	1,798,358		1,798,358	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	75,481	0	75,481	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,750,951	0	1,750,951	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
68.01	06801	CARDIAC REHAB	204,669	0	204,669	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	23,435		23,435	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,743		57,743	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,022		30,022	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,475,527		1,475,527	0	0	73.00
76.00	03480	ONCOLOGY	0		0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	2,212,770		2,212,770	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	390,590		390,590	0	0	88.01
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,700,327		2,700,327	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	248,127		248,127		0	92.00
93.00	04950	OTHER OP SVCS	175,160		175,160	0	0	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
200.00		Subtotal (see instructions)	17,322,740	0	17,322,740	0	0	200.00
201.00		Less Observation Beds	248,127		248,127		0	201.00
202.00		Total (see instructions)	17,074,613	0	17,074,613	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet C Part I Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,270,811		1,270,811			30.00
46.00	04600	OTHER LONG TERM CARE	517,638		517,638			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	500	711,058	711,558	0.818095	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	55,325	55,325	1.195535	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,563	7,124,509	7,182,072	0.231758	0.000000	54.00
60.00	06000	LABORATORY	155,746	5,649,709	5,805,455	0.309770	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	27,930	60,147	88,077	0.856989	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	424,102	3,115,016	3,539,118	0.494742	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
68.01	06801	CARDIAC REHAB	0	183,893	183,893	1.112979	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	5,280	232,650	237,930	0.098495	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,856	68,267	77,123	0.748713	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	28,362	28,362	1.058529	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	321,975	1,653,141	1,975,116	0.747058	0.000000	73.00
76.00	03480	ONCOLOGY	0	0	0	0.000000	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	0	1,980,788	1,980,788			88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	0	429,217	429,217			88.01
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	7,063	1,801,695	1,808,758	1.492918	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	287	192,360	192,647	1.287988	0.000000	92.00
93.00	04950	OTHER OP SVCS	2,500	536,907	539,407	0.324727	0.000000	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
200.00		Subtotal (see instructions)	2,800,251	23,823,044	26,623,295			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,800,251	23,823,044	26,623,295			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet C Part I Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
68.01	06801	CARDIAC REHAB	0.000000		68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03480	ONCOLOGY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC GRAND			88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST			88.01
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04950	OTHER OP SVCS	0.000000		93.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet C Part I Date/Time Prepared: 9/13/2023 6:00 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,859,630		2,859,630	0	2,859,630	30.00
46.00	04600	OTHER LONG TERM CARE	1,007,184		1,007,184	0	1,007,184	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	582,122		582,122	0	582,122	50.00
53.00	05300	ANESTHESIOLOGY	66,143		66,143	0	66,143	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,664,501		1,664,501	0	1,664,501	54.00
60.00	06000	LABORATORY	1,798,358		1,798,358	0	1,798,358	60.00
65.00	06500	RESPIRATORY THERAPY	75,481	0	75,481	0	75,481	65.00
66.00	06600	PHYSICAL THERAPY	1,750,951	0	1,750,951	0	1,750,951	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
68.01	06801	CARDIAC REHAB	204,669	0	204,669	0	204,669	68.01
69.00	06900	ELECTROCARDIOLOGY	23,435		23,435	0	23,435	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,743		57,743	0	57,743	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,022		30,022	0	30,022	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,475,527		1,475,527	0	1,475,527	73.00
76.00	03480	ONCOLOGY	0		0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	2,212,770		2,212,770	0	2,212,770	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	390,590		390,590	0	390,590	88.01
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,700,327		2,700,327	0	2,700,327	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	248,127		248,127		248,127	92.00
93.00	04950	OTHER OP SVCS	175,160		175,160	0	175,160	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
200.00		Subtotal (see instructions)	17,322,740	0	17,322,740	0	17,322,740	200.00
201.00		Less Observation Beds	248,127		248,127		248,127	201.00
202.00		Total (see instructions)	17,074,613	0	17,074,613	0	17,074,613	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet C Part I Date/Time Prepared: 9/13/2023 6:00 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,270,811		1,270,811			30.00
46.00	04600	OTHER LONG TERM CARE	517,638		517,638			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	500	711,058	711,558	0.818095	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	55,325	55,325	1.195535	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,563	7,124,509	7,182,072	0.231758	0.000000	54.00
60.00	06000	LABORATORY	155,746	5,649,709	5,805,455	0.309770	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	27,930	60,147	88,077	0.856989	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	424,102	3,115,016	3,539,118	0.494742	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
68.01	06801	CARDIAC REHAB	0	183,893	183,893	1.112979	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	5,280	232,650	237,930	0.098495	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,856	68,267	77,123	0.748713	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	28,362	28,362	1.058529	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	321,975	1,653,141	1,975,116	0.747058	0.000000	73.00
76.00	03480	ONCOLOGY	0	0	0	0.000000	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	0	1,980,788	1,980,788	1.117116	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	0	429,217	429,217	0.910006	0.000000	88.01
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	7,063	1,801,695	1,808,758	1.492918	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	287	192,360	192,647	1.287988	0.000000	92.00
93.00	04950	OTHER OP SVCS	2,500	536,907	539,407	0.324727	0.000000	93.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
200.00		Subtotal (see instructions)	2,800,251	23,823,044	26,623,295			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,800,251	23,823,044	26,623,295			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet C Part I Date/Time Prepared: 9/13/2023 6:00 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
68.01	06801	CARDIAC REHAB	0.000000		68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03480	ONCOLOGY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC GRAND	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	0.000000		88.01
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04950	OTHER OP SVCS	0.000000		93.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part II Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	41,723	711,558	0.058636	0	0	50.00
53.00	05300	ANESTHESIOLOGY	10,635	55,325	0.192228	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	114,427	7,182,072	0.015932	10,146	162	54.00
60.00	06000	LABORATORY	74,550	5,805,455	0.012841	37,975	488	60.00
65.00	06500	RESPIRATORY THERAPY	3,296	88,077	0.037422	4,717	177	65.00
66.00	06600	PHYSICAL THERAPY	53,765	3,539,118	0.015192	11,806	179	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
68.01	06801	CARDIAC REHAB	8,455	183,893	0.045978	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	807	237,930	0.003392	1,735	6	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,592	77,123	0.020642	1,064	22	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	824	28,362	0.029053	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,171	1,975,116	0.017301	47,132	815	73.00
76.00	03480	ONCOLOGY	0	0	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	75,808	1,980,788	0.038272	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	6,691	429,217	0.015589	0	0	88.01
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	49,710	1,808,758	0.027483	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	9,896	192,647	0.051369	0	0	92.00
93.00	04950	OTHER OP SVCS	145	539,407	0.000269	0	0	93.00
200.00		Total (lines 50 through 199)	486,495	24,834,846		114,575	1,849	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part IV Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	46,986	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04950	OTHER OP SVCS	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	46,986	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part IV | Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	711,558	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	46,986	0	55,325	0.849272	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,182,072	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	5,805,455	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	88,077	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,539,118	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
68.01	06801	CARDIAC REHAB	0	0	0	183,893	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	237,930	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	77,123	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	28,362	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,975,116	0.000000	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	0	0	0	1,980,788	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	0	0	0	429,217	0.000000	88.01
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	1,808,758	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	192,647	0.000000	92.00
93.00	04950	OTHER OP SVCS	0	0	0	539,407	0.000000	93.00
200.00		Total (lines 50 through 199)	0	46,986	0	24,834,846		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part IV | Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	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	10,146	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	37,975	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,717	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	11,806	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0.000000	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,735	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,064	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	47,132	0	0	0	73.00
76.00	03480	ONCOLOGY	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04950	OTHER OP SVCS	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		114,575	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part V Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.818095	0	282,354	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.195535	0	30,283	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.231758	0	2,220,155	0	0	54.00
60.00	06000	LABORATORY	0.309770	0	1,883,128	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.856989	0	21,973	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.494742	0	1,064,358	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	1.112979	0	85,946	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.098495	0	156,053	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.748713	0	38,979	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.058529	0	18,451	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.747058	0	1,289,347	2,103	0	73.00
76.00	03480	ONCOLOGY	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND						88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST						88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.492918	0	431,291	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.287988	0	123,940	0	0	92.00
93.00	04950	OTHER OP SVCS	0.324727	0	285,693	3,134	0	93.00
200.00		Subtotal (see instructions)		0	7,931,951	5,237	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	7,931,951	5,237	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part V Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	230,992	0		50.00
53.00	05300	ANESTHESIOLOGY	36,204	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	514,539	0		54.00
60.00	06000	LABORATORY	583,337	0		60.00
65.00	06500	RESPIRATORY THERAPY	18,831	0		65.00
66.00	06600	PHYSICAL THERAPY	526,583	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	CARDIAC REHAB	95,656	0		68.01
69.00	06900	ELECTROCARDIOLOGY	15,370	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,184	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,531	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	963,217	1,571		73.00
76.00	03480	ONCOLOGY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC GRAND				88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST				88.01
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	643,882	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	159,633	0		92.00
93.00	04950	OTHER OP SVCS	92,772	1,018		93.00
200.00		Subtotal (see instructions)	3,929,731	2,589		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,929,731	2,589		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1308 | Component CCN: 14-Z308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part IV | Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	46,986	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04950	OTHER OP SVCS	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	46,986	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1308 | Component CCN: 14-Z308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part IV | Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	711,558	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	46,986	0	55,325	0.849272	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,182,072	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	5,805,455	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	88,077	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,539,118	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
68.01	06801	CARDIAC REHAB	0	0	0	183,893	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	237,930	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	77,123	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	28,362	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,975,116	0.000000	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	0	0	0	1,980,788	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	0	0	0	429,217	0.000000	88.01
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	1,808,758	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	192,647	0.000000	92.00
93.00	04950	OTHER OP SVCS	0	0	0	539,407	0.000000	93.00
200.00		Total (lines 50 through 199)	0	46,986	0	24,834,846		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1308 | Component CCN: 14-Z308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part IV | Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	215	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	21,018	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	63,703	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	10,498	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	365,402	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0.000000	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,768	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	4,213	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	241,140	0	0	0	73.00
76.00	03480	ONCOLOGY	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04950	OTHER OP SVCS	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		707,957	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1308 | Component CCN: 14-Z308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part V Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.818095	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.195535	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.231758	0	0	0	0	54.00
60.00	06000	LABORATORY	0.309770	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.856989	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.494742	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	1.112979	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.098495	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.748713	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.058529	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.747058	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC GRAND						88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST						88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.492918	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.287988	0	0	0	0	92.00
93.00	04950	OTHER OP SVCS	0.324727	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1308 | Component CCN: 14-Z308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D Part V Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	CARDIAC REHAB	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03480	ONCOLOGY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC GRAND				88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST				88.01
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04950	OTHER OP SVCS	0	0		93.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1308	Period: From 05/01/2022 To 04/30/2023	Worksheet D-1 Date/Time Prepared: 9/13/2023 6:00 pm
	Title XVIII	Hospital	Cost

	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS			
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,599	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		237	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.	do	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		123	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		474	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)		361	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		51	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)		2,476	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		72	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)		460	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)		325	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
	SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		188.44	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)		2,859,630	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)	5	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)	x	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)	x	9,610	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)	x	516,741	25.00
26.00	Total swing-bed cost (see instructions)		2,343,787	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		515,843	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 minus line 36)	27	515,843	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)		2,176.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		156,713	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)		156,713	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D-1 | Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	60,176	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)	216,889	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	1,001,222	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	707,385	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	1,708,607	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)	114	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,176.55	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	248,127	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D-1 | Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Hospital | Cost

	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	114,044	2,859,630	0.039881	248,127	9,896	90.00
91.00	Nursing Program cost	0	2,859,630	0.000000	248,127	0	91.00
92.00	Allied health cost	0	2,859,630	0.000000	248,127	0	92.00
93.00	All other Medical Education	0	2,859,630	0.000000	248,127	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D-3 | Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		92,696		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.818095	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.195535	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.231758	10,146	2,351	54.00
60.00	06000	LABORATORY	0.309770	37,975	11,764	60.00
65.00	06500	RESPIRATORY THERAPY	0.856989	4,717	4,042	65.00
66.00	06600	PHYSICAL THERAPY	0.494742	11,806	5,841	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
68.01	06801	CARDIAC REHAB	1.112979	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.098495	1,735	171	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.748713	1,064	797	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.058529	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.747058	47,132	35,210	73.00
76.00	03480	ONCOLOGY	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC GRAND	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	0.000000		0	88.01
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1.492918	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.287988	0	0	92.00
93.00	04950	OTHER OP SVCS	0.324727	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		114,575	60,176	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)		114,575		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1308 | Component CCN: 14-Z308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet D-3 | Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.818095	215	176	50.00
53.00	05300	ANESTHESIOLOGY	1.195535	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.231758	21,018	4,871	54.00
60.00	06000	LABORATORY	0.309770	63,703	19,733	60.00
65.00	06500	RESPIRATORY THERAPY	0.856989	10,498	8,997	65.00
66.00	06600	PHYSICAL THERAPY	0.494742	365,402	180,780	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
68.01	06801	CARDIAC REHAB	1.112979	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.098495	1,768	174	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.748713	4,213	3,154	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.058529	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.747058	241,140	180,146	73.00
76.00	03480	ONCOLOGY	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC GRAND	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC MILL ST	0.000000		0	88.01
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1.492918	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.287988	0	0	92.00
93.00	04950	OTHER OP SVCS	0.324727	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		707,957	398,031	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)		707,957		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet E Part B Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,932,320	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,932,320	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	3,971,643	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	20,814	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,170,104	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,780,725	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	2,780,725	30.00
31.00	Primary payer payments	4,870	31.00
32.00	Subtotal (line 30 minus line 31)	2,775,855	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)	58,852	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	38,254	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	53,944	36.00
37.00	Subtotal (see instructions)	2,814,109	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)	2,814,109	40.00
40.01	Sequestration adjustment (see instructions)	51,780	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	2,603,492	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)	158,837	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: 14-1308	Period: From 05/01/2022 To 04/30/2023	Worksheet E Part B Date/Time Prepared: 9/13/2023 6:00 pm
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		131,465		3,011,869	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	11/09/2022	87,705	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	11/09/2022	1,065	04/25/2023	496,082	3.50
3.51		04/25/2023	6,839		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)		-7,904		-408,377	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)		123,561		2,603,492	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		63,875		158,837	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		187,436		2,762,329	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: 14-1308 | Component CCN: 14-Z308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,213,148		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	11/09/2022	17,245		0	3.01
3.02		04/25/2023	492,020		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)		509,265		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,722,413		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		347,510		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,069,923		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: 14-1308	Period: From 05/01/2022 To 04/30/2023	Worksheet E-1 Part II Date/Time Prepared: 9/13/2023 6:00 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-1308 | Component CCN: 14-Z308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet E-2 | Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,725,693	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)	402,011	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	785	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,127,704	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,127,704	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	2,127,704	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	18,980	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	2,108,724	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,108,724	0	19.00
19.01	Sequestration adjustment (see instructions)	38,801	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	1,722,413	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)	347,510	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: 14-1308	Period: From 05/01/2022 To 04/30/2023	Worksheet E-3 Part V Date/Time Prepared: 9/13/2023 6:00 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	216,889	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	216,889	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	219,058	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	219,058	19.00
20.00	Deductibles (exclude professional component)	28,316	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	190,742	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	190,742	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	320	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	208	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	320	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	190,950	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	190,950	30.00
30.01	Sequestration adjustment (see instructions)	3,514	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	123,561	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	63,875	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet G | Date/Time Prepared: 9/13/2023 6:00 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,851,626	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,258,518	0	0	0	4.00
5.00	Other receivable	305,647	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-904,000	0	0	0	6.00
7.00	Inventory	336,249	0	0	0	7.00
8.00	Prepaid expenses	263,060	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,111,100	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	62,855	0	0	0	12.00
13.00	Land improvements	419,030	0	0	0	13.00
14.00	Accumulated depreciation	-407,976	0	0	0	14.00
15.00	Buildings	10,027,628	0	0	0	15.00
16.00	Accumulated depreciation	-9,057,881	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	6,813,137	0	0	0	23.00
24.00	Accumulated depreciation	-5,664,721	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	927,041	0	0	0	27.00
28.00	Accumulated depreciation	-927,041	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	2,192,072	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,067,780	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,067,780	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	11,370,952	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	368,479	0	0	0	37.00
38.00	Salaries, wages, and fees payable	650,754	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	131,052	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	56,382	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,206,667	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	16,849	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	16,849	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	1,223,516	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	10,147,436				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)	10,147,436	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	11,370,952	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet G-1 | Date/Time Prepared: 9/13/2023 6:00 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		8,058,138		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,089,298				2.00
3.00	Total (sum of line 1 and line 2)		10,147,436		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		10,147,436		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)		10,147,436		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1308 | Period: From 05/01/2022 To 04/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 9/13/2023 6:00 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,081,084		1,081,084	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	380,237		380,237	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	517,638		517,638	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,978,959		1,978,959	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,978,959		1,978,959	17.00
18.00	Ancillary services	1,009,917	21,893,724	22,903,641	18.00
19.00	Outpatient services	0	661,054	661,054	19.00
20.00	RURAL HEALTH CLINIC GRAND	0	2,159,996	2,159,996	20.00
20.01	RURAL HEALTH CLINIC MILL ST	0	429,217	429,217	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.)	0	0	0	25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,988,876	25,143,991	28,132,867	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		15,988,162		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)		15,988,162		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1308	Period: From 05/01/2022 To 04/30/2023	Worksheet G-3 Date/Time Prepared: 9/13/2023 6:00 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	28,132,867	1.00
2.00	Less contractual allowances and discounts on patients' accounts	11,755,488	2.00
3.00	Net patient revenues (line 1 minus line 2)	16,377,379	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	15,988,162	4.00
5.00	Net income from service to patients (line 3 minus line 4)	389,217	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	195,896	6.00
7.00	Income from investments	18,564	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	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	935	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	14,775	22.00
23.00	Governmental appropriations	472,674	23.00
24.00	GRANT INCOME	275,319	24.00
24.01	MEDICARE AND MEDICAID INCENTIVE REV	0	24.01
24.02	GAIN ON DISPOSAL OF FIXED ASSETS	30,357	24.02
24.03	OTHER MISCELLANEOUS INCOME	56,076	24.03
24.04	340B	535,485	24.04
24.50	COVID-19 PHE PRF	100,000	24.50
25.00	Total other income (sum of lines 6-24)	1,700,081	25.00
26.00	Total (line 5 plus line 25)	2,089,298	26.00
27.00	OTHER EXPENSES	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,089,298	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1308 | Component CCN: 14-3472 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-1 | Date/Time Prepared: 9/13/2023 6:00 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	439,408	0	439,408	0	439,408	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	266,794	0	266,794	0	266,794	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	399,154	0	399,154	0	399,154	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,105,356	0	1,105,356	0	1,105,356	10.00
11.00	Physician Services Under Agreement	0	120,000	120,000	0	120,000	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	39,963	39,963	0	39,963	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	159,963	159,963	0	159,963	14.00
15.00	Medical Supplies	0	10,289	10,289	0	10,289	15.00
16.00	Transportation (Health Care Staff)	0	724	724	0	724	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	53,857	53,857	-53,857	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	64,870	64,870	-53,857	11,013	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,105,356	224,833	1,330,189	-53,857	1,276,332	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	105	105	0	105	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	105	105	0	105	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	3,909	3,909	0	3,909	29.00
30.00	Administrative Costs	0	6,378	6,378	0	6,378	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	10,287	10,287	0	10,287	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,105,356	235,225	1,340,581	-53,857	1,286,724	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1308 | Component CCN: 14-3472 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-1 | Date/Time Prepared: 9/13/2023 6:00 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-85,103	354,305		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	266,794		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	399,154		9.00
10.00	Subtotal (sum of lines 1 through 9)	-85,103	1,020,253		10.00
11.00	Physician Services Under Agreement	-120,000	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	-1,500	38,463		13.00
14.00	Subtotal (sum of lines 11 through 13)	-121,500	38,463		14.00
15.00	Medical Supplies	-1,346	8,943		15.00
16.00	Transportation (Health Care Staff)	0	724		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)	-1,346	9,667		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-207,949	1,068,383		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	105		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	105		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	3,909		29.00
30.00	Administrative Costs	-50	6,328		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-50	10,237		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-207,999	1,078,725		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1308 | Component CCN: 14-8626 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-1 | Date/Time Prepared: 9/13/2023 6:00 pm

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	13,012	0	13,012	0	13,012	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	90,499	0	90,499	0	90,499	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	41,417	0	41,417	0	41,417	9.00
10.00	Subtotal (sum of lines 1 through 9)	144,928	0	144,928	0	144,928	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	18,297	18,297	0	18,297	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	18,297	18,297	0	18,297	14.00
15.00	Medical Supplies	0	9,151	9,151	0	9,151	15.00
16.00	Transportation (Health Care Staff)	0	80	80	0	80	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	9,231	9,231	0	9,231	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	144,928	27,528	172,456	0	172,456	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	1,309	1,309	0	1,309	29.00
30.00	Administrative Costs	0	7,743	7,743	0	7,743	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	9,052	9,052	0	9,052	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	144,928	36,580	181,508	0	181,508	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1308 | Component CCN: 14-8626 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-1 | Date/Time Prepared: 9/13/2023 6:00 pm

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	13,012		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	90,499		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	41,417		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	144,928		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	18,297		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	18,297		14.00
15.00	Medical Supplies	0	9,151		15.00
16.00	Transportation (Health Care Staff)	0	80		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	9,231		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	172,456		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	34,448	35,757		29.00
30.00	Administrative Costs	0	7,743		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	34,448	43,500		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	34,448	215,956		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1308 | Component CCN: 14-3472 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-2 | Date/Time Prepared: 9/13/2023 6:00 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.32	3,249	3,570	4,712		1.00
2.00	Physician Assistant	0.00	0	1,785	0		2.00
3.00	Nurse Practitioner	1.74	4,878	1,785	3,106		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.06	8,127		7,818	8,127	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.06	8,127			8,127	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)					1,068,383	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					105	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,068,488	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999902	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					10,237	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,134,045	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,144,282	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,144,282	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,144,170	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,212,553	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1308 | Component CCN: 14-8626 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-2 | Date/Time Prepared: 9/13/2023 6:00 pm

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	0.04	107	4,200	168		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.61	1,797	2,100	1,281		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.65	1,904		1,449	1,904	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.65	1,904			1,904	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)					172,456	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					172,456	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					43,500	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					174,634	15.00
16.00	Total overhead (sum of lines 14 and 15)					218,134	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					218,134	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					218,134	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					390,590	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1308 Component CCN: 14-3472	Period: From 05/01/2022 To 04/30/2023	Worksheet M-3 Date/Time Prepared: 9/13/2023 6:00 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,212,553	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		7,611	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		2,204,942	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		8,127	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)		8,127	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		271.31	7.00

		Calculation of Limit (1)		
		Rate Period 1 (05/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 04/30/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	234.98	243.91	8.00
9.00	Rate for Program covered visits (see instructions)	234.98	243.91	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,301	658	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	305,709	160,493	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	466,202	16.00
16.01	Total program charges (see instructions)(from contractor's records)		440,932	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		336,810	16.04
16.05	Total program cost (see instructions)	0	336,810	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		45,190	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		78,687	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		336,810	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,321	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		341,131	22.00
23.00	Allowable bad debts (see instructions)		12,983	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		8,439	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		12,983	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)		349,570	26.00
26.01	Sequestration adjustment (see instructions)		6,432	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		285,007	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)		58,131	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: 14-1308 Component CCN: 14-8626	Period: From 05/01/2022 To 04/30/2023	Worksheet M-3 Date/Time Prepared: 9/13/2023 6:00 pm
	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)		390,590	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		390,590	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,904	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)		1,904	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		205.14	7.00

		Calculation of Limit (1)		
		Rate Period 1 (05/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 04/30/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	227.72	227.72	8.00
9.00	Rate for Program covered visits (see instructions)	205.14	205.14	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	143	80	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	29,335	16,411	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	45,746	16.00
16.01	Total program charges (see instructions)(from contractor's records)		52,531	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		33,030	16.04
16.05	Total program cost (see instructions)	0	33,030	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,458	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		9,540	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		33,030	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		33,030	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		33,030	26.00
26.01	Sequestration adjustment (see instructions)		608	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		56,868	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)		-24,446	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: 14-1308 | Component CCN: 14-3472 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-4 | Date/Time Prepared: 9/13/2023 6:00 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,020,253	1,020,253	1,020,253	1,020,253	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000057	0.000253	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	58	258	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,523	1,836	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,581	2,094	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,068,383	1,068,383	1,068,383	1,068,383	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,144,170	1,144,170	1,144,170	1,144,170	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.001480	0.001960	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1,693	2,243	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	3,274	4,337	0	0	10.00
11.00	Total number of injections/infusions (from your records)	14	62	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	233.86	69.95	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	11	25	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)	2,572	1,749	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)		7,611	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)		4,321	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-1308 | Component CCN: 14-3472 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-5 | Date/Time Prepared: 9/13/2023 6:00 pm

RHC I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		330,651	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		11/09/2022	592	3.50
3.51		04/25/2023	45,052	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)		-45,644	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		285,007	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		58,131	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		343,138	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: 14-1308 | Component CCN: 14-8626 | Period: From 05/01/2022 To 04/30/2023 | Worksheet M-5 | Date/Time Prepared: 9/13/2023 6:00 pm

RHC II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		21,580	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		01/30/2023	15,807	3.01
3.02		04/25/2023	19,512	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50		11/09/2022	31	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)		35,288	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		56,868	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		24,446	6.02
7.00	Total Medicare program liability (see instructions)		32,422	7.00

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