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: 14-1321	Period: From 07/01/2022 To 06/30/2023	Worksheet S Parts I-III Date/Time Prepared: 11/21/2023 8:21 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/21/2023 Time: 8:21 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANKLIN HOSPITAL (14-1321) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	134,042	17,649	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	59,492	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		78,248		0	10.00
10.01	RURAL HEALTH CLINIC II	0		2,192		0	10.01
200.00	TOTAL	0	193,534	98,089	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: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2023 8:21 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 201 BAILEY LANE	PO Box:			1.00
2.00	City: BENTON	State: IL	Zip Code: 62812	County: FRANKLIN	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	FRANKLIN HOSPITAL	141321	99914	1	08/01/2002	N	O	N	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	FRANKLIN HOSPITAL SWING BED	14Z321	99914		08/01/2002	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FRANKLIN RHC	143469	99914		07/06/2005	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	WEST FRANKFORT RHC	148510	99914		04/23/2010	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2022	06/30/2023	20.00
21.00	Type of Control (see instructions)	9		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2023 8:21 am

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
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: 14-1321	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/21/2023 8:21 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2023 8:21 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2023 8:21 am

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

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

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

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

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

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

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		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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.	N		108.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2023 8:21 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	85,922	0	0	118.01

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2023 8:21 am

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

							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/21/2023 8:21 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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	10/06/2023	Y	10/06/2023	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II Date/Time Prepared: 11/21/2023 8:21 am

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	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.	N	33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			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.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1321	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part II Date/Time Prepared: 11/21/2023 8:21 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2023 8:21 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	16	5,840	10,896.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		16	5,840	10,896.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		16	5,840	10,896.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		16				27.00
28.00	Observation Bed Days					441	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: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2023 8:21 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	299	0	454			1.00
2.00	HMO and other (see instructions)	38	8				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	185	0	318			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	16			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	484	0	788			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)	484	0	788	0.00	117.20	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	5,513	0	19,566	0.00	22.41	26.00
26.01	RURAL HEALTH CLINIC II	521	0	1,967	0.00	1.86	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	141.47	27.00
28.00	Observation Bed Days		0	441			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: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2023 8:21 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	110	0	195	1.00
2.00	HMO and other (see instructions)			12	4		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	110	0	195	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1321 | Component CCN: 14-3469 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 11/21/2023 8:21 am

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	201 BAILEY LANE	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	BENTON	IL	62812	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	12:00	18:00	09:00	20:00	09:00	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		FRANKLIN				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	20:00	09:00	20:00	09:00	20:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1321
Component CCN: 14-3469

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

Worksheet S-8

Date/Time Prepared:
11/21/2023 8:21 am

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	09:00	20:00	09:00	19:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1321 | Component CCN: 14-8510 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 11/21/2023 8:21 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			309 WEST ST. LOUIS STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WEST FRANKFORT		IL	62896	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			09:00	17:00	09:00	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		FRANKLIN				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	09:00	17:00	09:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1321
Component CCN: 14-8510

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

Worksheet S-8

Date/Time Prepared:
11/21/2023 8:21 am

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	09:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1321	Period: From 07/01/2022 To 06/30/2023	Worksheet S-10 Date/Time Prepared: 11/21/2023 8:21 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.424238	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,039,357	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,887,160	5.00
6.00	Medicaid charges	17,427,611	6.00
7.00	Medicaid cost (line 1 times line 6)	7,393,455	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	776	9.00
10.00	Stand-alone CHIP charges	2,007	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	851	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	75	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)	75	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)	220,591	321,354	541,945	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	93,583	321,354	414,937	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	93,583	321,354	414,937	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)	1,639,050	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	362,038	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	556,980	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,082,070	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	653,997	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,068,934	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,069,009	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/21/2023 8:21 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		249,992	249,992	139,843	389,835	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		641,725	641,725	69,795	711,520	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	139,214	2,692,136	2,831,350	0	2,831,350	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,948,372	1,999,071	3,947,443	-80,504	3,866,939	5.00
6.00	00600	MAINTENANCE & REPAIRS	294,162	208,079	502,241	0	502,241	6.00
7.00	00700	OPERATION OF PLANT	0	600,243	600,243	0	600,243	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	68,369	68,369	0	68,369	8.00
9.00	00900	HOUSEKEEPING	327,165	66,867	394,032	0	394,032	9.00
10.00	01000	DIETARY	222,840	196,147	418,987	-367,518	51,469	10.00
11.00	01100	CAFETERIA	0	0	0	367,518	367,518	11.00
13.00	01300	NURSING ADMINISTRATION	503,985	62,514	566,499	0	566,499	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	102,114	35,387	137,501	0	137,501	14.00
15.00	01500	PHARMACY	263,050	1,858,554	2,121,604	-1,429,944	691,660	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	280,473	103,389	383,862	0	383,862	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	462,520	2,500,743	2,963,263	0	2,963,263	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	585,137	361,936	947,073	0	947,073	50.00
53.00	05300	ANESTHESIOLOGY	0	136,885	136,885	0	136,885	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	516,640	181,476	698,116	-161,279	536,837	54.00
57.00	05700	CT SCAN	0	113,806	113,806	161,279	275,085	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	85,080	85,080	0	85,080	58.00
60.00	06000	LABORATORY	555,476	1,329,444	1,884,920	-7,900	1,877,020	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	40,205	40,205	7,900	48,105	63.00
65.00	06500	RESPIRATORY THERAPY	256,100	80,780	336,880	0	336,880	65.00
66.00	06600	PHYSICAL THERAPY	0	353,353	353,353	0	353,353	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	124,183	124,183	0	124,183	67.00
68.00	06800	SPEECH PATHOLOGY	0	79,403	79,403	0	79,403	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	66,102	66,102	0	66,102	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,429,944	1,429,944	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	175,298	173,970	349,268	0	349,268	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,740,313	766,637	3,506,950	0	3,506,950	88.00
88.01	08801	RURAL HEALTH CLINIC II	186,485	60,774	247,259	0	247,259	88.01
91.00	09100	EMERGENCY	715,932	2,472,889	3,188,821	0	3,188,821	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		129,134	129,134	-129,134	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,275,276	17,839,273	28,114,549	0	28,114,549	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	392,740	50,104	442,844	0	442,844	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	10,668,016	17,889,377	28,557,393	0	28,557,393	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/21/2023 8:21 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-8,182	381,653		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-3,683	707,837		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-9,119	2,822,231		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-117,205	3,749,734		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	502,241		6.00
7.00	00700	OPERATION OF PLANT	-141,113	459,130		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	68,369		8.00
9.00	00900	HOUSEKEEPING	0	394,032		9.00
10.00	01000	DIETARY	0	51,469		10.00
11.00	01100	CAFETERIA	-113,320	254,198		11.00
13.00	01300	NURSING ADMINISTRATION	0	566,499		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	137,501		14.00
15.00	01500	PHARMACY	-374,765	316,895		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,345	377,517		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-521,281	2,441,982		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-161,460	785,613		50.00
53.00	05300	ANESTHESIOLOGY	-122,094	14,791		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	536,837		54.00
57.00	05700	CT SCAN	0	275,085		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	85,080		58.00
60.00	06000	LABORATORY	0	1,877,020		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	48,105		63.00
65.00	06500	RESPIRATORY THERAPY	-15,330	321,550		65.00
66.00	06600	PHYSICAL THERAPY	0	353,353		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	124,183		67.00
68.00	06800	SPEECH PATHOLOGY	0	79,403		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	66,102		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,368	1,428,576		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	349,268		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-1,375	3,505,575		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	247,259		88.01
91.00	09100	EMERGENCY	-559,102	2,629,719		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,155,742	25,958,807		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	442,844		192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,155,742	26,401,651		200.00

RECLASSIFICATIONS | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/21/2023 8:21 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA COST				
1.00	CAFETERIA	11.00	195,466	172,052	1.00
	0		195,466	172,052	
	B - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	86,025	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	38,728	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	4,381	3.00
	0		0	129,134	
	C - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	84,885	1.00
	0		0	84,885	
	H - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,429,944	1.00
	0		0	1,429,944	
	J - CT SCAN COSTS				
1.00	CT SCAN	57.00	146,352	14,927	1.00
	0		146,352	14,927	
	K - BLOOD				
1.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	7,179	721	1.00
	0		7,179	721	
500.00	Grand Total: Increases		348,997	1,831,663	500.00

RECLASSIFICATIONS | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/21/2023 8:21 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA COST						
1.00	DIETARY	10.00	195,466	172,052	0		1.00
	0		195,466	172,052			
	B - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	129,134	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	0		3.00
	0		0	129,134			
	C - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	84,885	12		1.00
	0		0	84,885			
	H - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	1,429,944	0		1.00
	0		0	1,429,944			
	J - CT SCAN COSTS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	146,352	14,927	0		1.00
	0		146,352	14,927			
	K - BLOOD						
1.00	LABORATORY	60.00	7,179	721	0		1.00
	0		7,179	721			
500.00	Grand Total: Decreases		348,997	1,831,663			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 11/21/2023 8:21 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	18,401	0	0	0	0	1.00
2.00	Land Improvements	341,588	0	0	0	22,771	2.00
3.00	Buildings and Fixtures	2,053,037	148,650	0	148,650	0	3.00
4.00	Building Improvements	11,905,310	2,222,043	0	2,222,043	2,265	4.00
5.00	Fixed Equipment	279,928	17,239	0	17,239	0	5.00
6.00	Movable Equipment	10,182,743	736,155	0	736,155	44,970	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,781,007	3,124,087	0	3,124,087	70,006	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	24,781,007	3,124,087	0	3,124,087	70,006	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	18,401	0	1.00
2.00	Land Improvements	318,817	0	2.00
3.00	Buildings and Fixtures	2,201,687	0	3.00
4.00	Building Improvements	14,125,088	0	4.00
5.00	Fixed Equipment	297,167	0	5.00
6.00	Movable Equipment	10,873,928	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	27,835,088	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	27,835,088	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 11/21/2023 8:21 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	249,992	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	641,725	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	891,717	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	249,992		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	641,725		2.00
3.00	Total (sum of lines 1-2)	0	891,717		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 11/21/2023 8:21 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	16,961,160	0	16,961,160	0.634007	53,818	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,873,928	1,082,765	9,791,163	0.365993	31,067	2.00
3.00	Total (sum of lines 1-2)	27,835,088	1,082,765	26,752,323	1.000000	84,885	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	53,818	249,992	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	31,067	641,725	0	2.00
3.00	Total (sum of lines 1-2)	0	0	84,885	891,717	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	77,843	53,818	0	0	381,653	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	35,045	31,067	0	0	707,837	2.00
3.00	Total (sum of lines 1-2)	112,888	84,885	0	0	1,089,490	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/21/2023 8:21 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-8,182	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-3,683	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-417	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-7,536	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-4,169	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-4,722	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,377,626			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-370	ADMINISTRATIVE & GENERAL	5.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-113,320	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-1,368	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6,345	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	9	32.00
33.00	NH UTILITIES	B	-141,113	OPERATION OF PLANT	7.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/21/2023 8:21 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.00	MISCELLANEOUS INCOME - A&G	B	-28	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.02	LOBBYING PORTION OF DUES	A	-5,908	ADMINISTRATIVE & GENERAL	5.00	0	34.02
35.00	PROVIDER BENEFITS - ALL OTHER	A	-9,119	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
36.00	PROVIDER BENEFITS - 401K	A	-1,641	OPERATING ROOM	50.00	0	36.00
37.00	340B RETAIL PHARMACY COSTS	A	-374,765	PHARMACY	15.00	0	37.00
38.00	ADVERTISING	A	-94,055	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	NON-RHC PROVIDER TIME	A	-1,375	RURAL HEALTH CLINIC	88.00	0	39.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,155,742				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 11/21/2023 8:21 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	521,281	521,281	0	0	0	1.00
2.00	50.00	OPERATING ROOM	159,819	159,819	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	122,094	122,094	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	15,330	15,330	0	0	0	4.00
5.00	91.00	EMERGENCY	1,449,202	559,102	890,100	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			2,267,726	1,377,626	890,100		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	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	30.00	ADULTS & PEDIATRICS	0	0	0	521,281		1.00
2.00	50.00	OPERATING ROOM	0	0	0	159,819		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	122,094		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	15,330		4.00
5.00	91.00	EMERGENCY	0	0	0	559,102		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	1,377,626		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1321	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/21/2023 8:21 am

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					141	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					224	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					6.20	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,131.00	3,584.75	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	92.26	69.20	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	46.13	46.13	34.60			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					104,346	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					248,065	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					352,411	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					352,411	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					352,411	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					6,504	24.00
25.00	Assistants (line 4 times column 3, line 11)					7,750	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					14,254	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					2,263	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					16,517	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					16,517	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/21/2023 8:21 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	92.26	69.20	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	352,411		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	16,517		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	368,928		63.00
64.00	Total cost of outside supplier services (from your records)	352,723		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	14,254		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,263		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	16,517		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,263		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	2,263		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/21/2023 8:21 am

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		85	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		280	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		6.20	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	683.50	895.25	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	87.43	65.57	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	43.72	43.72	32.79			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	59,758	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	58,702	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	118,460	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	118,460	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	118,460	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	3,716	24.00
25.00	Assistants (line 4 times column 3, line 11)	9,181	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	12,897	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	2,263	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	15,160	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	15,160	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/21/2023 8:21 am

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	87.43	65.57	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	118,460	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	15,160	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	133,620	63.00
64.00	Total cost of outside supplier services (from your records)	124,183	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	12,897	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,263	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	15,160	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,263	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	2,263	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1321	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/21/2023 8:21 am

Speech Pathology — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					110	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					6.20	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	882.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	84.02	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	42.01	42.01	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					74,127	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					74,127	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					74,127	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					74,127	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					4,621	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					4,621	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					682	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					5,303	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					5,303	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/21/2023 8:21 am

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	84.02	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	74,127	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	5,303	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	79,430	63.00
64.00	Total cost of outside supplier services (from your records)	79,403	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	4,621	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	682	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	5,303	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	682	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	682	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/21/2023 8:21 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	381,653	381,653				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	707,837		707,837			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,822,231	908	0	2,823,139		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,749,734	39,992	232,832	530,464	4,553,022	5.00
6.00	00600	MAINTENANCE & REPAIRS	502,241	13,092	27,381	80,089	622,803	6.00
7.00	00700	OPERATION OF PLANT	459,130	41,967	573	0	501,670	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	68,369	3,598	0	0	71,967	8.00
9.00	00900	HOUSEKEEPING	394,032	1,931	2,743	89,074	487,780	9.00
10.00	01000	DIETARY	51,469	23,792	9,188	7,453	91,902	10.00
11.00	01100	CAFETERIA	254,198	0	0	53,218	307,416	11.00
13.00	01300	NURSING ADMINISTRATION	566,499	3,449	0	137,215	707,163	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	137,501	12,146	10,964	27,802	188,413	14.00
15.00	01500	PHARMACY	316,895	5,116	8,557	71,618	402,186	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	377,517	5,044	1,472	76,362	460,395	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,441,982	29,749	108,660	125,926	2,706,317	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	785,613	33,859	25,740	115,879	961,091	50.00
53.00	05300	ANESTHESIOLOGY	14,791	495	0	0	15,286	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	536,837	13,026	146,047	100,815	796,725	54.00
57.00	05700	CT SCAN	275,085	2,987	40,016	39,846	357,934	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	85,080	0	0	0	85,080	58.00
60.00	06000	LABORATORY	1,877,020	9,759	46,772	149,279	2,082,830	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	48,105	0	0	1,955	50,060	63.00
65.00	06500	RESPIRATORY THERAPY	321,550	4,879	19,857	69,726	416,012	65.00
66.00	06600	PHYSICAL THERAPY	353,353	4,725	1,445	0	359,523	66.00
67.00	06700	OCCUPATIONAL THERAPY	124,183	1,535	0	0	125,718	67.00
68.00	06800	SPEECH PATHOLOGY	79,403	523	0	0	79,926	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,102	0	0	0	66,102	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,428,576	0	0	0	1,428,576	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	349,268	15,975	0	47,727	412,970	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,505,575	56,479	3,699	746,072	4,311,825	88.00
88.01	08801	RURAL HEALTH CLINIC II	247,259	7,278	0	50,772	305,309	88.01
91.00	09100	EMERGENCY	2,629,719	12,245	21,891	194,920	2,858,775	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,958,807	344,549	707,837	2,716,212	25,814,776	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	442,844	37,104	0	106,927	586,875	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	26,401,651	381,653	707,837	2,823,139	26,401,651	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/21/2023 8:21 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,553,022					5.00
6.00	00600	MAINTENANCE & REPAIRS	129,785	752,588				6.00
7.00	00700	OPERATION OF PLANT	104,543	96,392	702,605			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14,997	8,263	8,848	104,075		8.00
9.00	00900	HOUSEKEEPING	101,648	4,435	4,749	0	598,612	9.00
10.00	01000	DIETARY	19,151	54,646	58,511	0	0	10.00
11.00	01100	CAFETERIA	64,062	0	0	0	20,355	11.00
13.00	01300	NURSING ADMINISTRATION	147,365	7,922	8,482	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	39,263	27,898	29,871	0	15,695	14.00
15.00	01500	PHARMACY	83,811	11,751	12,582	2,441	16,713	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	95,941	11,586	12,406	0	7,285	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	563,967	68,330	73,162	16,603	101,456	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	200,281	77,768	83,268	19,045	52,549	50.00
53.00	05300	ANESTHESIOLOGY	3,185	1,137	1,218	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	166,029	29,920	32,036	12,635	19,820	54.00
57.00	05700	CT SCAN	74,590	6,861	7,346	0	4,553	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	17,730	0	0	0	0	58.00
60.00	06000	LABORATORY	434,039	22,414	24,000	0	23,462	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	10,432	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	86,692	11,207	12,000	1,306	21,802	65.00
66.00	06600	PHYSICAL THERAPY	74,921	10,853	11,621	12,224	23,570	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,198	3,525	3,774	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	16,656	1,200	1,285	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,775	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	297,700	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	86,058	36,692	39,287	1,114	19,713	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	898,545	129,724	138,896	7,860	93,100	88.00
88.01	08801	RURAL HEALTH CLINIC II	63,623	16,716	17,898	1,812	0	88.01
91.00	09100	EMERGENCY	595,737	28,125	30,115	24,524	138,257	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,430,724	667,365	611,355	99,564	558,330	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	122,298	85,223	91,250	4,511	40,282	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,553,022	752,588	702,605	104,075	598,612	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/21/2023 8:21 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	224,210					10.00
11.00	01100	CAFETERIA	0	391,833				11.00
13.00	01300	NURSING ADMINISTRATION	0	24,694	895,626			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	8,512	0	309,652		14.00
15.00	01500	PHARMACY	0	11,131	0	1,768	542,383	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,910	0	719	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	203,362	34,562	151,492	12,354	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	22,777	99,833	21,087	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,044	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,378	115,618	3,383	0	54.00
57.00	05700	CT SCAN	0	10,430	45,714	7,086	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,228	0	58.00
60.00	06000	LABORATORY	0	45,226	198,230	203,626	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	608	2,665	338	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	13,376	58,629	4,308	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,115	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	16,890	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	542,383	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	20,848	12,487	54,734	485	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	104,810	0	9,278	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	410	0	88.01
91.00	09100	EMERGENCY	0	38,491	168,711	22,925	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	224,210	379,392	895,626	309,044	542,383	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,441	0	608	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	224,210	391,833	895,626	309,652	542,383	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/21/2023 8:21 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	614,242					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,290	3,949,895	0	3,949,895		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,951	1,569,650	0	1,569,650		50.00
53.00	05300	ANESTHESIOLOGY	1,209	24,079	0	24,079		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,788	1,252,332	0	1,252,332		54.00
57.00	05700	CT SCAN	120,493	635,007	0	635,007		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,717	110,755	0	110,755		58.00
60.00	06000	LABORATORY	145,157	3,178,984	0	3,178,984		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	997	65,100	0	65,100		63.00
65.00	06500	RESPIRATORY THERAPY	26,158	651,490	0	651,490		65.00
66.00	06600	PHYSICAL THERAPY	11,730	505,557	0	505,557		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,809	163,024	0	163,024		67.00
68.00	06800	SPEECH PATHOLOGY	1,303	100,370	0	100,370		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,366	103,133	0	103,133		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,317	2,313,976	0	2,313,976		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	9,751	694,139	0	694,139		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	37,316	5,731,354	0	5,731,354		88.00
88.01	08801	RURAL HEALTH CLINIC II	3,277	409,045	0	409,045		88.01
91.00	09100	EMERGENCY	94,613	4,000,273	0	4,000,273		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	614,242	25,458,163	0	25,458,163		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	943,488	0	943,488		192.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	614,242	26,401,651	0	26,401,651		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/21/2023 8:21 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	908	0	908	908	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18	39,992	232,832	272,842	171	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	13,092	27,381	40,473	26	6.00
7.00	00700	OPERATION OF PLANT	388	41,967	573	42,928	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,598	0	3,598	0	8.00
9.00	00900	HOUSEKEEPING	0	1,931	2,743	4,674	29	9.00
10.00	01000	DIETARY	0	23,792	9,188	32,980	2	10.00
11.00	01100	CAFETERIA	0	0	0	0	17	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,449	0	3,449	44	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	12,146	10,964	23,110	9	14.00
15.00	01500	PHARMACY	0	5,116	8,557	13,673	23	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,044	1,472	6,516	25	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	366	29,749	108,660	138,775	41	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	57,200	33,859	25,740	116,799	37	50.00
53.00	05300	ANESTHESIOLOGY	1,103	495	0	1,598	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	151	13,026	146,047	159,224	33	54.00
57.00	05700	CT SCAN	294	2,987	40,016	43,297	13	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	9,759	46,772	56,531	48	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	1	63.00
65.00	06500	RESPIRATORY THERAPY	4,544	4,879	19,857	29,280	23	65.00
66.00	06600	PHYSICAL THERAPY	0	4,725	1,445	6,170	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,535	0	1,535	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	523	0	523	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	151	15,975	0	16,126	15	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	442	56,479	3,699	60,620	237	88.00
88.01	08801	RURAL HEALTH CLINIC II	151	7,278	0	7,429	16	88.01
91.00	09100	EMERGENCY	2,716	12,245	21,891	36,852	63	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,524	344,549	707,837	1,119,910	873	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	37,104	0	37,104	35	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	67,524	381,653	707,837	1,157,014	908	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/21/2023 8:21 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	273,013					5.00
6.00	00600	MAINTENANCE & REPAIRS	7,783	48,282				6.00
7.00	00700	OPERATION OF PLANT	6,269	6,184	55,381			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	899	530	697	5,724		8.00
9.00	00900	HOUSEKEEPING	6,095	285	374	0	11,457	9.00
10.00	01000	DIETARY	1,148	3,506	4,612	0	0	10.00
11.00	01100	CAFETERIA	3,841	0	0	0	390	11.00
13.00	01300	NURSING ADMINISTRATION	8,837	508	669	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	2,354	1,790	2,355	0	300	14.00
15.00	01500	PHARMACY	5,026	754	992	134	320	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,753	743	978	0	139	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,818	4,384	5,767	913	1,942	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,010	4,989	6,563	1,047	1,006	50.00
53.00	05300	ANESTHESIOLOGY	191	73	96	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,956	1,919	2,525	695	379	54.00
57.00	05700	CT SCAN	4,473	440	579	0	87	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,063	0	0	0	0	58.00
60.00	06000	LABORATORY	26,027	1,438	1,892	0	449	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	626	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	5,198	719	946	72	417	65.00
66.00	06600	PHYSICAL THERAPY	4,493	696	916	672	451	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,571	226	298	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	999	77	101	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	826	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,851	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,160	2,354	3,097	61	377	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	53,874	8,324	10,946	432	1,782	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,815	1,072	1,411	100	0	88.01
91.00	09100	EMERGENCY	35,723	1,804	2,374	1,350	2,647	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	265,679	42,815	48,188	5,476	10,686	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,334	5,467	7,193	248	771	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	273,013	48,282	55,381	5,724	11,457	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/21/2023 8:21 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	42,248					10.00
11.00	01100	CAFETERIA	0	4,248				11.00
13.00	01300	NURSING ADMINISTRATION	0	268	13,775			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	92	0	30,010		14.00
15.00	01500	PHARMACY	0	121	0	171	21,214	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	281	0	70	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,320	375	2,330	1,197	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	247	1,535	2,044	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	198	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	286	1,778	328	0	54.00
57.00	05700	CT SCAN	0	113	703	687	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	119	0	58.00
60.00	06000	LABORATORY	0	490	3,049	19,734	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	7	41	33	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	145	902	417	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	108	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,637	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	21,214	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,928	135	842	47	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,136	0	899	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	40	0	88.01
91.00	09100	EMERGENCY	0	417	2,595	2,222	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,248	4,113	13,775	29,951	21,214	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	135	0	59	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	42,248	4,248	13,775	30,010	21,214	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/21/2023 8:21 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,505					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	432	228,294	0	228,294		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	755	147,032	0	147,032		50.00
53.00	05300	ANESTHESIOLOGY	29	2,185	0	2,185		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,177	178,300	0	178,300		54.00
57.00	05700	CT SCAN	2,849	53,241	0	53,241		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	159	1,341	0	1,341		58.00
60.00	06000	LABORATORY	3,416	113,074	0	113,074		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	24	732	0	732		63.00
65.00	06500	RESPIRATORY THERAPY	618	38,737	0	38,737		65.00
66.00	06600	PHYSICAL THERAPY	277	13,783	0	13,783		66.00
67.00	06700	OCCUPATIONAL THERAPY	90	3,720	0	3,720		67.00
68.00	06800	SPEECH PATHOLOGY	31	1,731	0	1,731		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	150	2,613	0	2,613		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,071	40,136	0	40,136		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	231	32,373	0	32,373		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	882	139,132	0	139,132		88.00
88.01	08801	RURAL HEALTH CLINIC II	77	13,960	0	13,960		88.01
91.00	09100	EMERGENCY	2,237	88,284	0	88,284		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,505	1,098,668	0	1,098,668		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	58,346	0	58,346		192.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	14,505	1,157,014	0	1,157,014		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/21/2023 8:21 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	69,379					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		676,770				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	165	0	10,369,283			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,270	222,613	1,948,372	-4,553,022	21,848,629	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,380	26,179	294,162	0	622,803	6.00
7.00	00700	OPERATION OF PLANT	7,629	548	0	0	501,670	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	654	0	0	0	71,967	8.00
9.00	00900	HOUSEKEEPING	351	2,623	327,165	0	487,780	9.00
10.00	01000	DIETARY	4,325	8,785	27,374	0	91,902	10.00
11.00	01100	CAFETERIA	0	0	195,466	0	307,416	11.00
13.00	01300	NURSING ADMINISTRATION	627	0	503,985	0	707,163	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	2,208	10,483	102,114	0	188,413	14.00
15.00	01500	PHARMACY	930	8,181	263,050	0	402,186	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	917	1,407	280,473	0	460,395	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,408	103,891	462,520	0	2,706,317	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,155	24,610	425,618	0	961,091	50.00
53.00	05300	ANESTHESIOLOGY	90	0	0	0	15,286	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,368	139,637	370,288	0	796,725	54.00
57.00	05700	CT SCAN	543	38,260	146,352	0	357,934	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	85,080	58.00
60.00	06000	LABORATORY	1,774	44,719	548,297	0	2,082,830	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	7,179	0	50,060	63.00
65.00	06500	RESPIRATORY THERAPY	887	18,985	256,100	0	416,012	65.00
66.00	06600	PHYSICAL THERAPY	859	1,382	0	0	359,523	66.00
67.00	06700	OCCUPATIONAL THERAPY	279	0	0	0	125,718	67.00
68.00	06800	SPEECH PATHOLOGY	95	0	0	0	79,926	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	66,102	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,428,576	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,904	0	175,298	0	412,970	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,267	3,537	2,740,313	0	4,311,825	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,323	0	186,485	0	305,309	88.01
91.00	09100	EMERGENCY	2,226	20,930	715,932	0	2,858,775	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,634	676,770	9,976,543	-4,553,022	21,261,754	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,745	0	392,740	0	586,875	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	381,653	707,837	2,823,139		4,553,022	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.500987	1.045905	0.272260		0.208389	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			908		273,013	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000088		0.012496	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: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/21/2023 8:21 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	59,564					6.00
7.00	00700	OPERATION OF PLANT	7,629	51,935				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	654	654	140,721			8.00
9.00	00900	HOUSEKEEPING	351	351	0	11,175		9.00
10.00	01000	DIETARY	4,325	4,325	0	0	6,130	10.00
11.00	01100	CAFETERIA	0	0	0	380	0	11.00
13.00	01300	NURSING ADMINISTRATION	627	627	0	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	2,208	2,208	0	293	0	14.00
15.00	01500	PHARMACY	930	930	3,300	312	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	917	917	0	136	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,408	5,408	22,449	1,894	5,560	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,155	6,155	25,751	981	0	50.00
53.00	05300	ANESTHESIOLOGY	90	90	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,368	2,368	17,084	370	0	54.00
57.00	05700	CT SCAN	543	543	0	85	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,774	1,774	0	438	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	887	887	1,766	407	0	65.00
66.00	06600	PHYSICAL THERAPY	859	859	16,528	440	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	279	279	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	95	95	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,904	2,904	1,506	368	570	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,267	10,267	10,627	1,738	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,323	1,323	2,450	0	0	88.01
91.00	09100	EMERGENCY	2,226	2,226	33,161	2,581	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,819	45,190	134,622	10,423	6,130	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,745	6,745	6,099	752	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	752,588	702,605	104,075	598,612	224,210	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.634947	13.528545	0.739584	53.567069	36.575856	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	48,282	55,381	5,724	11,457	42,248	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.810590	1.066352	0.040676	1.025235	6.892007	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: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/21/2023 8:21 am

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	8,378					11.00
13.00	01300	NURSING ADMINISTRATION	528	4,369				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	182	0	1,211,859			14.00
15.00	01500	PHARMACY	238	0	6,921	1,429,944		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	554	0	2,814	0	60,009,212	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	739	739	48,349	0	1,786,838	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	487	487	82,527	0	3,121,467	50.00
53.00	05300	ANESTHESIOLOGY	0	0	8,001	0	118,136	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	564	564	13,241	0	4,863,961	54.00
57.00	05700	CT SCAN	223	223	27,733	0	11,771,523	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	4,806	0	656,252	58.00
60.00	06000	LABORATORY	967	967	796,911	0	14,182,120	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	13	13	1,323	0	97,416	63.00
65.00	06500	RESPIRATORY THERAPY	286	286	16,858	0	2,555,537	65.00
66.00	06600	PHYSICAL THERAPY	0	0	4,363	0	1,145,990	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	372,088	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	127,323	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	66,102	0	621,886	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,429,944	4,427,211	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	267	267	1,900	0	952,648	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,241	0	36,309	0	3,645,521	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	1,605	0	320,141	88.01
91.00	09100	EMERGENCY	823	823	89,718	0	9,243,154	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,112	4,369	1,209,481	1,429,944	60,009,212	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	266	0	2,378	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	391,833	895,626	309,652	542,383	614,242	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	46.769277	204.995651	0.255518	0.379304	0.010236	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,248	13,775	30,010	21,214	14,505	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.507042	3.152895	0.024764	0.014836	0.000242	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/21/2023 8:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,949,895		3,949,895	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,569,650		1,569,650	0	0	50.00
53.00	05300	ANESTHESIOLOGY	24,079		24,079	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,252,332		1,252,332	0	0	54.00
57.00	05700	CT SCAN	635,007		635,007	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	110,755		110,755	0	0	58.00
60.00	06000	LABORATORY	3,178,984		3,178,984	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	65,100		65,100	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	651,490	0	651,490	0	0	65.00
66.00	06600	PHYSICAL THERAPY	505,557	0	505,557	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	163,024	0	163,024	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	100,370	0	100,370	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	103,133		103,133	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,313,976		2,313,976	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	694,139		694,139	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,731,354		5,731,354	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	409,045		409,045	0	0	88.01
91.00	09100	EMERGENCY	4,000,273		4,000,273	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,434,868		1,434,868		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	26,893,031	0	26,893,031	0	0	200.00
201.00		Less Observation Beds	1,434,868		1,434,868		0	201.00
202.00		Total (see instructions)	25,458,163	0	25,458,163	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/21/2023 8:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,108,288		1,108,288			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,584	3,113,883	3,121,467	0.502857	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,276	116,860	118,136	0.203824	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,738	4,833,223	4,863,961	0.257472	0.000000	54.00
57.00	05700	CT SCAN	129,515	11,642,008	11,771,523	0.053944	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,207	653,045	656,252	0.168769	0.000000	58.00
60.00	06000	LABORATORY	403,945	13,778,175	14,182,120	0.224154	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	9,098	88,318	97,416	0.668268	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	468,627	2,086,910	2,555,537	0.254933	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	126,773	1,019,217	1,145,990	0.441153	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	70,118	301,970	372,088	0.438133	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	13,771	113,552	127,323	0.788310	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	183,321	438,565	621,886	0.165839	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	347,425	4,079,786	4,427,211	0.522671	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	952,648	952,648	0.728642	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,645,521	3,645,521			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	320,141	320,141			88.01
91.00	09100	EMERGENCY	3,336	9,239,818	9,243,154	0.432782	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,205	677,345	678,550	2.114609	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	2,908,227	57,100,985	60,009,212			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,908,227	57,100,985	60,009,212			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/21/2023 8:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		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
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 11/21/2023 8:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	147,032	3,121,467	0.047103	3,111	147	50.00
53.00	05300	ANESTHESIOLOGY	2,185	118,136	0.018496	912	17	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	178,300	4,863,961	0.036657	20,247	742	54.00
57.00	05700	CT SCAN	53,241	11,771,523	0.004523	92,148	417	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,341	656,252	0.002043	3,207	7	58.00
60.00	06000	LABORATORY	113,074	14,182,120	0.007973	207,069	1,651	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	732	97,416	0.007514	3,567	27	63.00
65.00	06500	RESPIRATORY THERAPY	38,737	2,555,537	0.015158	291,216	4,414	65.00
66.00	06600	PHYSICAL THERAPY	13,783	1,145,990	0.012027	19,221	231	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,720	372,088	0.009998	10,620	106	67.00
68.00	06800	SPEECH PATHOLOGY	1,731	127,323	0.013595	7,938	108	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,613	621,886	0.004202	79,926	336	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,136	4,427,211	0.009066	217,773	1,974	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	32,373	952,648	0.033982	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	139,132	3,645,521	0.038165	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	13,960	320,141	0.043606	0	0	88.01
91.00	09100	EMERGENCY	88,284	9,243,154	0.009551	1,093	10	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	82,931	678,550	0.122218	1,205	147	92.00
200.00		Total (lines 50 through 199)	953,305	58,900,924		959,253	10,334	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/21/2023 8:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/21/2023 8:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	3,121,467	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	118,136	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,863,961	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	11,771,523	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	656,252	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	14,182,120	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	97,416	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,555,537	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,145,990	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	372,088	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	127,323	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	621,886	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,427,211	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	952,648	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,645,521	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	320,141	0.000000	88.01
91.00	09100	EMERGENCY	0	0	0	9,243,154	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	678,550	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	58,900,924		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/21/2023 8:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	3,111	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	912	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	20,247	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	92,148	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	3,207	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	207,069	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	3,567	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	291,216	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	19,221	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	10,620	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	7,938	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	79,926	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	217,773	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
91.00	09100	EMERGENCY	0.000000	1,093	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,205	0	0	0	92.00
200.00		Total (lines 50 through 199)		959,253	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/21/2023 8:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.502857	0	1,176,274	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.203824	0	33,908	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.257472	0	1,359,060	0	0	54.00
57.00	05700	CT SCAN	0.053944	0	3,472,349	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.168769	0	170,265	0	0	58.00
60.00	06000	LABORATORY	0.224154	0	4,031,452	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.668268	0	37,267	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.254933	0	758,913	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.441153	0	202,521	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.438133	0	44,576	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.788310	0	16,987	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.165839	0	180,587	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.522671	0	2,292,381	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.728642	0	787,152	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
91.00	09100	EMERGENCY	0.432782	0	2,294,120	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.114609	0	306,678	0	0	92.00
200.00		Subtotal (see instructions)		0	17,164,490	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	17,164,490	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/21/2023 8:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	591,498	0	50.00
53.00	05300	ANESTHESIOLOGY	6,911	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	349,920	0	54.00
57.00	05700	CT SCAN	187,312	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	28,735	0	58.00
60.00	06000	LABORATORY	903,666	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	24,904	0	63.00
65.00	06500	RESPIRATORY THERAPY	193,472	0	65.00
66.00	06600	PHYSICAL THERAPY	89,343	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,530	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,391	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,948	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,198,161	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	573,552	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
91.00	09100	EMERGENCY	992,854	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	648,504	0	92.00
200.00		Subtotal (see instructions)	5,851,701	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	5,851,701	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/21/2023 8:21 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,229	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	895	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	454	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	144	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)	174	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	7	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)	9	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	299	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)	59	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)	126	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)	3,949,895	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	1,319	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)	1,878	25.00
26.00	Total swing-bed cost (see instructions)	1,037,864	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,912,031	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,912,031	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	3,253.67	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	972,847	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)	972,847	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/21/2023 8:21 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	285,005	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,257,852	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)	191,967	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	409,962	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	601,929	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)	441	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,253.67	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,434,868	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/21/2023 8:21 am

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	228,294	3,949,895	0.057797	1,434,868	82,931	90.00
91.00	Nursing Program cost	0	3,949,895	0.000000	1,434,868	0	91.00
92.00	Allied health cost	0	3,949,895	0.000000	1,434,868	0	92.00
93.00	All other Medical Education	0	3,949,895	0.000000	1,434,868	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/21/2023 8:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		574,143		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.502857	3,111	1,564	50.00
53.00	05300	ANESTHESIOLOGY	0.203824	912	186	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.257472	20,247	5,213	54.00
57.00	05700	CT SCAN	0.053944	92,148	4,971	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.168769	3,207	541	58.00
60.00	06000	LABORATORY	0.224154	207,069	46,415	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.668268	3,567	2,384	63.00
65.00	06500	RESPIRATORY THERAPY	0.254933	291,216	74,241	65.00
66.00	06600	PHYSICAL THERAPY	0.441153	19,221	8,479	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.438133	10,620	4,653	67.00
68.00	06800	SPEECH PATHOLOGY	0.788310	7,938	6,258	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.165839	79,926	13,255	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.522671	217,773	113,824	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.728642	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	0.432782	1,093	473	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.114609	1,205	2,548	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		959,253	285,005	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)		959,253		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1321 | Component CCN: 14-Z321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/21/2023 8:21 am

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	0.502857	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.203824	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.257472	1,309	337	54.00
57.00	05700	CT SCAN	0.053944	1,967	106	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.168769	0	0	58.00
60.00	06000	LABORATORY	0.224154	38,572	8,646	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.668268	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.254933	18,793	4,791	65.00
66.00	06600	PHYSICAL THERAPY	0.441153	57,345	25,298	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.438133	32,273	14,140	67.00
68.00	06800	SPEECH PATHOLOGY	0.788310	837	660	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.165839	16,145	2,677	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.522671	60,012	31,367	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.728642	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	0.432782	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.114609	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		227,253	88,022	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)		227,253		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1321	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/21/2023 8:21 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,851,701	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,851,701	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	5,910,218	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)	32,953	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,592,466	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,284,799	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	3,284,799	30.00
31.00	Primary payer payments	800	31.00
32.00	Subtotal (line 30 minus line 31)	3,283,999	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)	399,074	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	259,398	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	313,820	36.00
37.00	Subtotal (see instructions)	3,543,397	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,543,397	40.00
40.01	Sequestration adjustment (see instructions)	70,868	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,454,880	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)	17,649	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: 14-1321	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/21/2023 8:21 am
	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: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2023 8:21 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		728,655		3,282,450	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/14/2023	6,924	06/20/2023	192,072	3.01
3.02		06/30/2023	289,721		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	02/14/2023	19,642	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)		296,645		172,430	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)		1,025,300		3,454,880	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		134,042		17,649	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,159,342		3,472,529	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: 14-1321 | Component CCN: 14-Z321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2023 8:21 am

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		406,090		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	06/20/2023	211,763		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		211,763		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)		617,853		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		59,492		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		677,345		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: 14-1321	Period: From 07/01/2022 To 06/30/2023	Worksheet E-1 Part II Date/Time Prepared: 11/21/2023 8:21 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1321 | Component CCN: 14-Z321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-2 | Date/Time Prepared: 11/21/2023 8:21 am

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)	607,948	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)	88,902	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	185	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)	696,850	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	696,850	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)	696,850	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,956	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	690,894	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)	421	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	274	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	170	0	18.00
19.00	Total (see instructions)	691,168	0	19.00
19.01	Sequestration adjustment (see instructions)	13,823	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	617,853	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)	59,492	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: 14-1321	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part V Date/Time Prepared: 11/21/2023 8:21 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,257,852	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	1,257,852	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,270,431	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,270,431	19.00
20.00	Deductibles (exclude professional component)	114,996	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,155,435	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,155,435	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	42,410	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	27,567	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	26,571	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,183,002	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,183,002	30.00
30.01	Sequestration adjustment (see instructions)	23,660	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,025,300	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)	134,042	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: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G | Date/Time Prepared: 11/21/2023 8:21 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3,693,887	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	2,596,804	0	0	0	4.00
5.00	Other receivable	963,445	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	602,669	0	0	0	7.00
8.00	Prepaid expenses	207,560	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)	8,064,365	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	18,401	0	0	0	12.00
13.00	Land improvements	318,817	0	0	0	13.00
14.00	Accumulated depreciation	-101,054	0	0	0	14.00
15.00	Buildings	16,326,775	0	0	0	15.00
16.00	Accumulated depreciation	-11,790,535	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	297,167	0	0	0	19.00
20.00	Accumulated depreciation	-79,192	0	0	0	20.00
21.00	Automobiles and trucks	19,499	0	0	0	21.00
22.00	Accumulated depreciation	-9,749	0	0	0	22.00
23.00	Major movable equipment	9,771,664	0	0	0	23.00
24.00	Accumulated depreciation	-7,735,573	0	0	0	24.00
25.00	Minor equipment depreciable	1,082,765	0	0	0	25.00
26.00	Accumulated depreciation	-767,780	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	55,801	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,407,006	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,126,782	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)	1,126,782	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	16,598,153	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,218,386	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,110,313	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	575,724	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,323,159	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,227,582	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,303,753	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	104,862	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,408,615	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	6,636,197	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	9,961,956				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)	9,961,956	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	16,598,153	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-1 | Date/Time Prepared: 11/21/2023 8:21 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		9,007,888		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		954,066				2.00
3.00	Total (sum of line 1 and line 2)		9,961,954		0		3.00
4.00	ROUNDING	2		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)		2		0		10.00
11.00	Subtotal (line 3 plus line 10)		9,961,956		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)		9,961,956		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	ROUNDING		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: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/21/2023 8:21 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	902,056		902,056	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	196,353		196,353	5.00
6.00	Swing bed - NF	9,879		9,879	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,108,288		1,108,288	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)	1,108,288		1,108,288	17.00
18.00	Ancillary services	1,795,398	43,218,160	45,013,558	18.00
19.00	Outpatient services	4,541	9,917,163	9,921,704	19.00
20.00	RURAL HEALTH CLINIC	0	3,645,521	3,645,521	20.00
20.01	RURAL HEALTH CLINIC II	0	320,141	320,141	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PROFESSIONAL FEES	143,875	1,424,781	1,568,656	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,052,102	58,525,766	61,577,868	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		28,557,393		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)		28,557,393		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1321 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-3 | Date/Time Prepared: 11/21/2023 8:21 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	61,577,868	1.00
2.00	Less contractual allowances and discounts on patients' accounts	34,962,439	2.00
3.00	Net patient revenues (line 1 minus line 2)	26,615,429	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,557,393	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,941,964	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	61,827	6.00
7.00	Income from investments	16,592	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	7,536	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	113,320	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	1,368	17.00
18.00	Revenue from sale of medical records and abstracts	6,345	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	89,681	22.00
23.00	Governmental appropriations	1,311,487	23.00
24.00	NURSING HOME UTILITY REIMBURSEMENT	141,113	24.00
24.01	340B DRUG INCOME	561,291	24.01
24.02	MISCELLANEOUS INCOME	37,913	24.02
24.50	COVID-19 PHE Funding	547,557	24.50
25.00	Total other income (sum of lines 6-24)	2,896,030	25.00
26.00	Total (line 5 plus line 25)	954,066	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	954,066	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1321 | Component CCN: 14-3469 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/21/2023 8:21 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,167,551	0	1,167,551	0	1,167,551	1.00
2.00	Physician Assistant	114,341	0	114,341	0	114,341	2.00
3.00	Nurse Practitioner	506,272	0	506,272	0	506,272	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	724,331	0	724,331	0	724,331	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,512,495	0	2,512,495	0	2,512,495	10.00
11.00	Physician Services Under Agreement	0	219,909	219,909	0	219,909	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	3,125	3,125	0	3,125	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	223,034	223,034	0	223,034	14.00
15.00	Medical Supplies	0	56,519	56,519	0	56,519	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	56,519	56,519	0	56,519	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,512,495	279,553	2,792,048	0	2,792,048	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	119,162	119,162	0	119,162	29.00
30.00	Administrative Costs	227,818	367,922	595,740	0	595,740	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	227,818	487,084	714,902	0	714,902	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,740,313	766,637	3,506,950	0	3,506,950	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1321 | Component CCN: 14-3469 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/21/2023 8:21 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,167,551		1.00
2.00	Physician Assistant	0	114,341		2.00
3.00	Nurse Practitioner	0	506,272		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	724,331		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,512,495		10.00
11.00	Physician Services Under Agreement	-1,375	218,534		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	3,125		13.00
14.00	Subtotal (sum of lines 11 through 13)	-1,375	221,659		14.00
15.00	Medical Supplies	0	56,519		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	56,519		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-1,375	2,790,673		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	119,162		29.00
30.00	Administrative Costs	0	595,740		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	714,902		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,375	3,505,575		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1321 | Component CCN: 14-8510 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/21/2023 8:21 am

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	135,934	0	135,934	0	135,934	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	50,551	0	50,551	0	50,551	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	186,485	0	186,485	0	186,485	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	2,045	2,045	0	2,045	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	2,045	2,045	0	2,045	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	186,485	2,045	188,530	0	188,530	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	18,015	18,015	0	18,015	29.00
30.00	Administrative Costs	0	40,714	40,714	0	40,714	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	58,729	58,729	0	58,729	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	186,485	60,774	247,259	0	247,259	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1321 | Component CCN: 14-8510 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/21/2023 8:21 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	135,934		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	50,551		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	186,485		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	2,045		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	2,045		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	188,530		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	18,015		29.00
30.00	Administrative Costs	0	40,714		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	58,729		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	247,259		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1321 | Component CCN: 14-3469 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-2 | Date/Time Prepared: 11/21/2023 8:21 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	4.04	8,543	4,200	16,968		1.00
2.00	Physician Assistant	0.61	2,292	2,100	1,281		2.00
3.00	Nurse Practitioner	3.46	8,731	2,100	7,266		3.00
4.00	Subtotal (sum of lines 1 through 3)	8.11	19,566		25,515	25,515	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)	8.11	19,566			25,515	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,790,673	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)					2,790,673	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)					714,902	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,225,779	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,940,681	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,940,681	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,940,681	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					5,731,354	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1321 | Component CCN: 14-8510 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-2 | Date/Time Prepared: 11/21/2023 8:21 am

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC II Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.88	1,967	2,100	1,848		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.88	1,967		1,848	1,967	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)	0.88	1,967			1,967	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)					188,530	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)					188,530	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)					58,729	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					161,786	15.00
16.00	Total overhead (sum of lines 14 and 15)					220,515	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					220,515	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					220,515	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					409,045	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1321 Component CCN: 14-3469	Period: From 07/01/2022 To 06/30/2023	Worksheet M-3 Date/Time Prepared: 11/21/2023 8:21 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			5,731,354	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			31,980	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			5,699,374	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			25,515	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)			25,515	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			223.37	7.00
		Calculation of Limit (1)			
		Rate Period 1 (07/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 06/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	240.27	249.40		8.00
9.00	Rate for Program covered visits (see instructions)	223.37	223.37		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	2,650	2,857		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	591,931	638,168		11.00
12.00	Program covered visits for mental health services (from contractor records)	3	3		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	670	670		13.00
14.00	Limit adjustment for mental health services (see instructions)	670	670		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,231,439		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,058,868		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.)		922,580		16.04
16.05	Total program cost (see instructions)	0	922,580		16.05
17.00	Primary payer amounts		1		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		78,214		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		191,662		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		922,579		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		18,453		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		941,032		22.00
23.00	Allowable bad debts (see instructions)		108,637		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		70,614		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		101,119		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		1,011,646		26.00
26.01	Sequestration adjustment (see instructions)		20,233		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		913,165		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)		78,248		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: 14-1321 Component CCN: 14-8510	Period: From 07/01/2022 To 06/30/2023	Worksheet M-3 Date/Time Prepared: 11/21/2023 8:21 am
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		409,045	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)		409,045	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,967	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)		1,967	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		207.95	7.00

		Calculation of Limit (1)		
		Rate Period 1 (07/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 06/30/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	291.10	302.17	8.00
9.00	Rate for Program covered visits (see instructions)	207.95	207.95	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	235	286	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	48,868	59,474	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	108,342	16.00
16.01	Total program charges (see instructions)(from contractor's records)		113,714	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.)		76,836	16.04
16.05	Total program cost (see instructions)	0	76,836	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		12,297	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		14,430	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		76,836	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)		76,836	22.00
23.00	Allowable bad debts (see instructions)		6,438	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		4,185	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		6,438	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		81,021	26.00
26.01	Sequestration adjustment (see instructions)		1,620	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		77,209	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)		2,192	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: 14-1321 | Component CCN: 14-3469 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-4 | Date/Time Prepared: 11/21/2023 8:21 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,512,495	2,512,495	2,512,495	2,512,495	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000170	0.000823	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	427	2,068	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	5,089	7,987	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	5,516	10,055	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,790,673	2,790,673	2,790,673	2,790,673	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,940,681	2,940,681	2,940,681	2,940,681	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.001977	0.003603	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	5,814	10,595	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	11,330	20,650	0	0	10.00
11.00	Total number of injections/infusions (from your records)	42	204	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	269.76	101.23	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	26	113	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)	7,014	11,439	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)	31,980	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)	18,453	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1321 Component CCN: 14-3469	Period: From 07/01/2022 To 06/30/2023	Worksheet M-5 Date/Time Prepared: 11/21/2023 8:21 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		925,252	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		02/14/2023	73,332	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		06/20/2023	85,419	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)		-12,087	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		913,165	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		78,248	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		991,413	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: 14-1321 Component CCN: 14-8510	Period: From 07/01/2022 To 06/30/2023	Worksheet M-5 Date/Time Prepared: 11/21/2023 8:21 am
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		85,247	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		02/14/2023	4,696	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		06/20/2023	12,734	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)		-8,038	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		77,209	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		2,192	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		79,401	7.00

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