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: 14-1306	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/28/2024 7:33 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/28/2024 Time: 7:33 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 COMMUNITY HOSPITAL OF STAUNTON (14-1306) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Patrick Garvey		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	Patrick Garvey			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	-22,885	-101,164	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	15,419	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-20,439		0	10.00
200.00	TOTAL	0	-7,466	-121,603	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2024 7:33 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 400 CALDWELL STREET	PO Box:			1.00
2.00	City: STAUNTON	State: IL	Zip Code: 62088-1499	County: MACOUPIN	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	COMMUNITY HOSPITAL OF STAUNTON	141306	41180	1	08/01/2000	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	COMMUNITY HOSPITAL OF STAUNTON-SWB	14Z306	41180		08/01/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									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	COMMUNITY CLINIC OF STAUNTON	148580	41180		10/20/2017	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2024 7:33 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.	1		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.	1		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.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2024 7:33 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: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2024 7:33 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: 14-1306	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/28/2024 7:33 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)?		68.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2024 7:33 am

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2024 7:33 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	222,824	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.	Y	N	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		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: ANDERSON HEALTH CARE	Contractor's Name: NATIONAL GOVERNMENT SERVICES	Contractor's Number: 06101	141.00
142.00	Street: 6800 STATE ROUTE 162	PO Box:		142.00
143.00	City: MARYVILLE	State: IL	Zip Code: 62062	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: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2024 7:33 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: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/28/2024 7:33 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/18/2024	Y	04/18/2024	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/28/2024 7:33 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.		33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JOSHUA	WILKS	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4309	JOSHUA.WILKS@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1306	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Prepared: 5/28/2024 7:33 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.	CPA		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: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2024 7:33 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	25	9,125	6,144.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	6,144.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	6,144.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2024 7:33 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)	106	0	256			1.00
2.00	HMO and other (see instructions)	100	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	478	0	801			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)	584	0	1,073			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)	584	0	1,073	0.00	92.06	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						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	774	0	4,534	0.00	8.68	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	100.74	27.00
28.00	Observation Bed Days		0	354			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: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2024 7:33 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	51	0	104	1.00
2.00	HMO and other (see instructions)			31	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	51	0	104	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
26.25	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: 14-1306 | Component CCN: 14-8580 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/28/2024 7:33 am

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	325 N CALDWELL	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	STAUNTON	IL	62088	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:30	16:30	08:30	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
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.	N	0	13.01

		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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1306
Component CCN: 14-8580

Period:
From 01/01/2023
To 12/31/2023

Worksheet S-8

Date/Time Prepared:
5/28/2024 7:33 am

RHC I | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		MACOUPIN				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:30	18:00	08:30	16:30	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:30				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 5/28/2024 7:33 am

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.392121	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,061,947	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	8,419,081	6.00
7.00	Medicaid cost (line 1 times line 6)	3,301,298	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	255,735	0	255,735	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	100,279	0	100,279	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	100,279	0	100,279	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	802,676	26.00
27.00	Medicare reimbursable bad debts (see instructions)	117,993	27.00
27.01	Medicare allowable bad debts (see instructions)	181,528	27.01
28.00	Non-Medicare bad debt amount (see instructions)	621,148	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	307,100	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	407,379	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	407,379	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1306	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/28/2024 7:33 am

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

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

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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/28/2024 7:33 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		1,395,741	1,395,741	22,944	1,418,685	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	260,472	260,472	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	40,404	1,401,340	1,441,744	0	1,441,744	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,174,574	2,100,057	3,274,631	-25,926	3,248,705	5.00
7.00	00700	OPERATION OF PLANT	224,700	587,605	812,305	0	812,305	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	55,312	55,312	0	55,312	8.00
9.00	00900	HOUSEKEEPING	294,561	18,139	312,700	0	312,700	9.00
10.00	01000	DIETARY	165,377	59,238	224,615	-92,131	132,484	10.00
11.00	01100	CAFETERIA	0	0	0	92,131	92,131	11.00
13.00	01300	NURSING ADMINISTRATION	132,503	6,292	138,795	0	138,795	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	133,917	4,326	138,243	0	138,243	14.00
15.00	01500	PHARMACY	201,377	1,472,987	1,674,364	-1,340,058	334,306	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	63,552	18,609	82,161	0	82,161	16.00
17.00	01700	SOCIAL SERVICE	101,088	6,104	107,192	0	107,192	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,234,697	294,045	1,528,742	-4,882	1,523,860	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	565,942	950,367	1,516,309	-97,508	1,418,801	54.00
60.00	06000	LABORATORY	487,415	526,923	1,014,338	0	1,014,338	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	166,019	476,685	642,704	-20,573	622,131	65.00
66.00	06600	PHYSICAL THERAPY	66,242	828,885	895,127	0	895,127	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	157,330	157,330	0	157,330	67.00
68.00	06800	SPEECH PATHOLOGY	0	71,098	71,098	0	71,098	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	139,168	139,168	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,340,058	1,340,058	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	201,199	99,127	300,326	0	300,326	76.00
76.01	03950	WOUND CARE	0	6,250	6,250	0	6,250	76.01
76.97	07697	CARDIAC REHABILITATION	86,943	13,123	100,066	0	100,066	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	728,680	80,381	809,061	0	809,061	88.00
91.00	09100	EMERGENCY	1,021,060	1,715,129	2,736,189	-16,205	2,719,984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		257,490	257,490	-257,490	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,090,250	12,602,583	19,692,833	0	19,692,833	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	35,651	9,663	45,314	0	45,314	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	7,125,901	12,612,246	19,738,147	0	19,738,147	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/28/2024 7:33 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	-235,611	1,183,074		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-21,879	238,593		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-111,140	1,330,604		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-848,140	2,400,565		5.00
7.00	00700	OPERATION OF PLANT	12,953	825,258		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	55,312		8.00
9.00	00900	HOUSEKEEPING	0	312,700		9.00
10.00	01000	DIETARY	0	132,484		10.00
11.00	01100	CAFETERIA	-4,604	87,527		11.00
13.00	01300	NURSING ADMINISTRATION	23,377	162,172		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	138,243		14.00
15.00	01500	PHARMACY	0	334,306		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,695	76,466		16.00
17.00	01700	SOCIAL SERVICE	-35,756	71,436		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-134,315	1,389,545		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	-36,768	1,382,033		54.00
60.00	06000	LABORATORY	-20,663	993,675		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	622,131		65.00
66.00	06600	PHYSICAL THERAPY	0	895,127		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	157,330		67.00
68.00	06800	SPEECH PATHOLOGY	0	71,098		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-62,021	77,147		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-24,942	1,315,116		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	300,326		76.00
76.01	03950	WOUND CARE	0	6,250		76.01
76.97	07697	CARDIAC REHABILITATION	0	100,066		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	809,061		88.00
91.00	09100	EMERGENCY	-498,391	2,221,593		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)	-2,003,595	17,689,238		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	45,314		192.00
194.00	07950	MOB	0	0		194.00
194.01	07951	MOB	0	0		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,003,595	17,734,552		200.00

RECLASSIFICATIONS | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/28/2024 7:33 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	236,390		1.00
	TOTALS		0	236,390		
	B - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	235,611		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	21,879		2.00
	TOTALS		0	257,490		
	C - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	25,926		1.00
	TOTALS		0	25,926		
	D - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,340,058		1.00
	TOTALS		0	1,340,058		
	E - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	67,833	24,298		1.00
	TOTALS		67,833	24,298		
	F - MEDICAL SUPPLIES CHARGED TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	139,168		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		0	139,168		
500.00	Grand Total: Increases		67,833	2,023,330		500.00

RECLASSIFICATIONS | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/28/2024 7:33 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	236,390	9		1.00
	TOTALS		0	236,390			
	B - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	257,490	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	257,490			
	C - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	25,926	12		1.00
	TOTALS		0	25,926			
	D - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	1,340,058	0		1.00
	TOTALS		0	1,340,058			
	E - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	67,833	24,298	0		1.00
	TOTALS		67,833	24,298			
	F - MEDICAL SUPPLIES CHARGED TO PATIENTS						
1.00	ADULTS & PEDIATRICS	30.00	0	4,882	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	97,508	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	20,573	0		3.00
4.00	EMERGENCY	91.00	0	16,205	0		4.00
	TOTALS		0	139,168			
500.00	Grand Total: Decreases		67,833	2,023,330			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/28/2024 7:33 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	546,486	0	0	0	0	1.00
2.00	Land Improvements	2,298,714	0	0	0	0	2.00
3.00	Buildings and Fixtures	18,555,532	782,185	0	782,185	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	526,461	0	0	0	0	5.00
6.00	Movable Equipment	2,359,507	63,512	0	63,512	314,237	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,286,700	845,697	0	845,697	314,237	8.00
9.00	Reconciling Items	740,368	55,034	0	55,034	795,402	9.00
10.00	Total (line 8 minus line 9)	23,546,332	790,663	0	790,663	-481,165	10.00

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	546,486	0				1.00
2.00	Land Improvements	2,298,714	0				2.00
3.00	Buildings and Fixtures	19,337,717	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	526,461	0				5.00
6.00	Movable Equipment	2,108,782	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	24,818,160	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	24,818,160	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/28/2024 7:33 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	1,395,741	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,395,741	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,395,741	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	1,395,741	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 5/28/2024 7:33 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	22,709,378	0	22,709,378	0.915031	23,723	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,108,782	0	2,108,782	0.084969	2,203	2.00
3.00	Total (sum of lines 1-2)	24,818,160	0	24,818,160	1.000000	25,926	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	23,723	1,159,351	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2,203	236,390	0	2.00
3.00	Total (sum of lines 1-2)	0	0	25,926	1,395,741	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	23,723	0	0	1,183,074	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,203	0	0	238,593	2.00
3.00	Total (sum of lines 1-2)	0	25,926	0	0	1,421,667	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/28/2024 7:33 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	-235,611	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-21,879	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-111,744	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	-835	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-2,769	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-653,369			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-193,789			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-4,604	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	B	-62,021	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-24,942	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-3,934	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)	B	-19,101	ADMINISTRATIVE & GENERAL	5.00	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	IHA LOBBYING FEES	A	-3,475	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/28/2024 7:33 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	TAXES	A	-3,895	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MEDICAID PROVIDER TAX	A	-471,691	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-44,399	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.04
33.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.05
33.06	PUBLIC RELATIONS OTHER	A	-11,977	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	DOMESTIC CLAIMS	A	-126,973	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	SCHOLARSHIP	A	-1,425	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	MARKETING EXPENSE	A	-3,432	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	DONATIONS	A	-1,730	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,003,595				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/28/2024 7:33 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	ANDERSON HO	97,370	81,537	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	ANDERSON HO	983,900	1,158,336	2.00
3.00	7.00	OPERATION OF PLANT	ANDERSON HO	15,722	0	3.00
3.01	13.00	NURSING ADMINISTRATION	ANDERSON HO	23,377	0	3.01
3.02	16.00	MEDICAL RECORDS & LIBRARY	ANDERSON HO	80,400	82,161	3.02
4.00	17.00	SOCIAL SERVICE	ANDERSON HO	71,436	107,192	4.00
4.01	54.00	RADIOLOGY-DIAGNOSTIC	ANDERSON HO	17,113	53,881	4.01
4.02	0.00			0	0	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,289,318	1,483,107	5.00

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

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

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

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

6.00	B		0.00	SW IL HLTH FAC	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-1306	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/28/2024 7:33 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	15,833	0		1.00
2.00	-174,436	0		2.00
3.00	15,722	0		3.00
3.01	23,377	0		3.01
3.02	-1,761	0		3.02
4.00	-35,756	0		4.00
4.01	-36,768	0		4.01
4.02	0	0		4.02
5.00	-193,789			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/28/2024 7:33 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	134,315	134,315	0	0	0	1.00
2.00	60.00	LABORATORY	20,663	20,663	0	0	0	2.00
3.00	91.00	EMERGENCY	1,317,810	498,391	819,419	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,472,788	653,369	819,419		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	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	134,315		1.00
2.00	60.00	LABORATORY	0	0	0	20,663		2.00
3.00	91.00	EMERGENCY	0	0	0	498,391		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	653,369		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/28/2024 7:33 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)					365	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					6.55	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	961.00	4,920.00	3,562.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	132.13	97.88	73.41	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)	48.94	48.94	36.71			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)					126,977	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					481,570	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					261,486	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					870,033	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)					870,033	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)					870,033	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)					17,863	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)					17,863	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)					2,391	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					20,254	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)					20,254	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: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/28/2024 7:33 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)	97.88	73.41	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)	870,033		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	20,254		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)	890,287		63.00
64.00	Total cost of outside supplier services (from your records)	813,519		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	17,863		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,391		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	20,254		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	2,391		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	2,391		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: 14-1306	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/28/2024 7:33 am

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		37	1.00
2.00	Line 1 multiplied by 15 hours per week		555	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		257	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		6.55	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	1,090.00	961.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	92.76	69.57	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)	46.38	46.38	34.79			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)	101,108	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	66,857	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	167,965	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)	167,965	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)	167,965	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)	11,920	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)	11,920	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)	1,683	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	13,603	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)	13,603	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: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/28/2024 7:33 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)	92.76	69.57	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)	167,965	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	13,603	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)	181,568	63.00
64.00	Total cost of outside supplier services (from your records)	156,470	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	11,920	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,683	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	13,603	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	1,683	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	1,683	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: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/28/2024 7:33 am

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					24	1.00
2.00	Line 1 multiplied by 15 hours per week					360	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					166	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					6.55	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	1,184.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	89.14	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)	44.57	44.57	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)					105,542	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)					105,542	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)					105,542	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)					105,542	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)					7,399	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)					7,399	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)					1,087	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					8,486	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)					8,486	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: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/28/2024 7:33 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)	89.14	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)	105,542		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	8,486		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)	114,028		63.00
64.00	Total cost of outside supplier services (from your records)	71,099		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	7,399		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,087		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	8,486		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	1,087		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	1,087		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: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/28/2024 7:33 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,183,074	1,183,074				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	238,593		238,593			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,330,604	2,137	431	1,333,172		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,400,565	150,860	30,424	221,002	2,802,851	5.00
7.00	00700	OPERATION OF PLANT	825,258	395,377	79,736	42,278	1,342,649	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	55,312	15,644	3,155	0	74,111	8.00
9.00	00900	HOUSEKEEPING	312,700	9,648	1,946	55,423	379,717	9.00
10.00	01000	DIETARY	132,484	29,470	5,943	18,353	186,250	10.00
11.00	01100	CAFETERIA	87,527	18,483	3,727	12,763	122,500	11.00
13.00	01300	NURSING ADMINISTRATION	162,172	4,465	901	24,931	192,469	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	138,243	27,015	5,448	25,197	195,903	14.00
15.00	01500	PHARMACY	334,306	21,640	4,364	37,890	398,200	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	76,466	17,319	3,493	11,958	109,236	16.00
17.00	01700	SOCIAL SERVICE	71,436	0	0	19,020	90,456	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,389,545	108,234	21,828	232,314	1,751,921	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,382,033	51,398	10,365	106,485	1,550,281	54.00
60.00	06000	LABORATORY	993,675	40,346	8,137	91,710	1,133,868	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	622,131	19,312	3,895	31,237	676,575	65.00
66.00	06600	PHYSICAL THERAPY	895,127	60,520	12,205	12,464	980,316	66.00
67.00	06700	OCCUPATIONAL THERAPY	157,330	0	0	0	157,330	67.00
68.00	06800	SPEECH PATHOLOGY	71,098	4,098	827	0	76,023	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	77,147	0	0	0	77,147	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,315,116	0	0	0	1,315,116	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	300,326	16,394	3,306	37,857	357,883	76.00
76.01	03950	WOUND CARE	6,250	2,217	447	0	8,914	76.01
76.97	07697	CARDIAC REHABILITATION	100,066	15,230	3,071	16,359	134,726	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	809,061	87,710	17,689	137,105	1,051,565	88.00
91.00	09100	EMERGENCY	2,221,593	34,526	6,963	192,118	2,455,200	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)	17,689,238	1,132,043	228,301	1,326,464	17,621,207	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	45,314	51,031	10,292	6,708	113,345	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
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)	17,734,552	1,183,074	238,593	1,333,172	17,734,552	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/28/2024 7:33 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,802,851					5.00
7.00	00700	OPERATION OF PLANT	252,030	1,594,679				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,911	39,306	127,328			8.00
9.00	00900	HOUSEKEEPING	71,277	24,241	0	475,235		9.00
10.00	01000	DIETARY	34,961	74,044	0	25,082	320,337	10.00
11.00	01100	CAFETERIA	22,995	46,438	0	15,731	0	11.00
13.00	01300	NURSING ADMINISTRATION	36,129	11,219	0	3,800	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	36,773	67,874	0	22,992	0	14.00
15.00	01500	PHARMACY	74,747	54,371	0	18,418	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,505	43,513	0	14,740	0	16.00
17.00	01700	SOCIAL SERVICE	16,980	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	328,855	271,939	127,328	92,118	320,337	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	291,005	129,137	0	43,745	0	54.00
60.00	06000	LABORATORY	212,839	101,370	0	34,339	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	127,001	48,522	0	16,437	0	65.00
66.00	06600	PHYSICAL THERAPY	184,016	152,055	0	51,508	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,533	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,270	10,297	0	3,488	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,481	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	246,862	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	67,179	41,189	0	13,953	0	76.00
76.01	03950	WOUND CARE	1,673	5,569	0	1,887	0	76.01
76.97	07697	CARDIAC REHABILITATION	25,290	38,264	0	12,962	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	197,390	220,370	0	74,650	0	88.00
91.00	09100	EMERGENCY	460,873	86,746	0	29,385	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)	2,781,575	1,466,464	127,328	475,235	320,337	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	21,276	128,215	0	0	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,802,851	1,594,679	127,328	475,235	320,337	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/28/2024 7:33 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	207,664					11.00
13.00	01300	NURSING ADMINISTRATION	5,265	248,882				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	5,321	0	328,863			14.00
15.00	01500	PHARMACY	8,002	19,591	3,833	577,162		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,525	0	103	0	190,622	16.00
17.00	01700	SOCIAL SERVICE	4,017	9,835	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	49,057	120,120	15,674	0	8,552	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,488	0	12,449	0	63,498	54.00
60.00	06000	LABORATORY	19,367	0	163,301	0	44,634	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,597	0	6,680	0	5,704	65.00
66.00	06600	PHYSICAL THERAPY	2,632	0	5,703	0	21,485	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	249	0	2,812	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	945	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	78,212	0	750	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	568,217	18,376	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	7,995	0	226	0	2,190	76.00
76.01	03950	WOUND CARE	0	0	0	0	51	76.01
76.97	07697	CARDIAC REHABILITATION	3,455	0	1,485	0	856	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	28,954	0	15,274	8,945	0	88.00
91.00	09100	EMERGENCY	40,572	99,336	25,292	0	20,769	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)	206,247	248,882	328,481	577,162	190,622	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	1,417	0	382	0	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	207,664	248,882	328,863	577,162	190,622	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/28/2024 7:33 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	121,288					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	121,288	3,207,189	-235,609	2,971,580		30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,112,603	0	2,112,603		54.00
60.00	06000	LABORATORY	0	1,709,718	0	1,709,718		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	235,609	235,609		64.00
65.00	06500	RESPIRATORY THERAPY	0	887,516	0	887,516		65.00
66.00	06600	PHYSICAL THERAPY	0	1,397,715	0	1,397,715		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	189,924	0	189,924		67.00
68.00	06800	SPEECH PATHOLOGY	0	105,023	0	105,023		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	170,590	0	170,590		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,148,571	0	2,148,571		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	490,615	0	490,615		76.00
76.01	03950	WOUND CARE	0	18,094	0	18,094		76.01
76.97	07697	CARDIAC REHABILITATION	0	217,038	0	217,038		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,597,148	0	1,597,148		88.00
91.00	09100	EMERGENCY	0	3,218,173	0	3,218,173		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)	121,288	17,469,917	0	17,469,917		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	264,635	0	264,635		192.00
194.00	07950	MOB	0	0	0	0		194.00
194.01	07951	MOB	0	0	0	0		194.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	121,288	17,734,552	0	17,734,552		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/28/2024 7:33 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	2,137	431	2,568	2,568	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	452	150,860	30,424	181,736	425	5.00
7.00	00700	OPERATION OF PLANT	0	395,377	79,736	475,113	81	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,644	3,155	18,799	0	8.00
9.00	00900	HOUSEKEEPING	0	9,648	1,946	11,594	107	9.00
10.00	01000	DIETARY	0	29,470	5,943	35,413	35	10.00
11.00	01100	CAFETERIA	0	18,483	3,727	22,210	25	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,465	901	5,366	48	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	27,015	5,448	32,463	48	14.00
15.00	01500	PHARMACY	37,661	21,640	4,364	63,665	73	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,319	3,493	20,812	23	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	37	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	108,234	21,828	130,062	450	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	167,376	51,398	10,365	229,139	205	54.00
60.00	06000	LABORATORY	0	40,346	8,137	48,483	176	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	19,312	3,895	23,207	60	65.00
66.00	06600	PHYSICAL THERAPY	0	60,520	12,205	72,725	24	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,098	827	4,925	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	16,394	3,306	19,700	73	76.00
76.01	03950	WOUND CARE	0	2,217	447	2,664	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	15,230	3,071	18,301	31	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	87,710	17,689	105,399	264	88.00
91.00	09100	EMERGENCY	0	34,526	6,963	41,489	370	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)	205,489	1,132,043	228,301	1,565,833	2,555	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	51,031	10,292	61,323	13	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
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)	205,489	1,183,074	238,593	1,627,156	2,568	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/28/2024 7:33 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	182,161					5.00
7.00	00700	OPERATION OF PLANT	16,380	491,574				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	904	12,116	31,819			8.00
9.00	00900	HOUSEKEEPING	4,633	7,472	0	23,806		9.00
10.00	01000	DIETARY	2,272	22,825	0	1,256	61,801	10.00
11.00	01100	CAFETERIA	1,495	14,315	0	788	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,348	3,458	0	190	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	2,390	20,923	0	1,152	0	14.00
15.00	01500	PHARMACY	4,858	16,760	0	923	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,333	13,413	0	738	0	16.00
17.00	01700	SOCIAL SERVICE	1,104	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,373	83,829	31,819	4,616	61,801	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,913	39,808	0	2,191	0	54.00
60.00	06000	LABORATORY	13,833	31,248	0	1,720	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	8,254	14,957	0	823	0	65.00
66.00	06600	PHYSICAL THERAPY	11,960	46,872	0	2,580	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,919	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	927	3,174	0	175	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	941	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,044	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,366	12,697	0	699	0	76.00
76.01	03950	WOUND CARE	109	1,717	0	95	0	76.01
76.97	07697	CARDIAC REHABILITATION	1,644	11,795	0	649	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	12,829	67,931	0	3,739	0	88.00
91.00	09100	EMERGENCY	29,949	26,740	0	1,472	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)	180,778	452,050	31,819	23,806	61,801	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	1,383	39,524	0	0	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	182,161	491,574	31,819	23,806	61,801	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/28/2024 7:33 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	38,833					11.00
13.00	01300	NURSING ADMINISTRATION	984	12,394				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	995	0	57,971			14.00
15.00	01500	PHARMACY	1,496	976	676	89,427		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	472	0	18	0	36,809	16.00
17.00	01700	SOCIAL SERVICE	751	490	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,177	5,981	2,763	0	1,652	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,205	0	2,194	0	12,252	54.00
60.00	06000	LABORATORY	3,621	0	28,787	0	8,622	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,234	0	1,178	0	1,102	65.00
66.00	06600	PHYSICAL THERAPY	492	0	1,005	0	4,150	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	44	0	543	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	183	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	13,787	0	145	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	88,041	3,550	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,495	0	40	0	423	76.00
76.01	03950	WOUND CARE	0	0	0	0	10	76.01
76.97	07697	CARDIAC REHABILITATION	646	0	262	0	165	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,414	0	2,692	1,386	0	88.00
91.00	09100	EMERGENCY	7,586	4,947	4,458	0	4,012	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)	38,568	12,394	57,904	89,427	36,809	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	265	0	67	0	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,833	12,394	57,971	89,427	36,809	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/28/2024 7:33 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	2,382					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,382	355,905	0	355,905		30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	308,907	0	308,907		54.00
60.00	06000	LABORATORY	0	136,490	0	136,490		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	50,815	0	50,815		65.00
66.00	06600	PHYSICAL THERAPY	0	139,808	0	139,808		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,506	0	2,506		67.00
68.00	06800	SPEECH PATHOLOGY	0	9,384	0	9,384		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,873	0	14,873		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	107,635	0	107,635		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	39,493	0	39,493		76.00
76.01	03950	WOUND CARE	0	4,595	0	4,595		76.01
76.97	07697	CARDIAC REHABILITATION	0	33,493	0	33,493		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	199,654	0	199,654		88.00
91.00	09100	EMERGENCY	0	121,023	0	121,023		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)	2,382	1,524,581	0	1,524,581		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	102,575	0	102,575		192.00
194.00	07950	MOB	0	0	0	0		194.00
194.01	07951	MOB	0	0	0	0		194.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,382	1,627,156	0	1,627,156		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/28/2024 7:33 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	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	74,187					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		74,187				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	134	134	7,085,497			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,460	9,460	1,174,574	-2,802,851	14,931,701	5.00
7.00	00700	OPERATION OF PLANT	24,793	24,793	224,700	0	1,342,649	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	981	981	0	0	74,111	8.00
9.00	00900	HOUSEKEEPING	605	605	294,561	0	379,717	9.00
10.00	01000	DIETARY	1,848	1,848	97,544	0	186,250	10.00
11.00	01100	CAFETERIA	1,159	1,159	67,833	0	122,500	11.00
13.00	01300	NURSING ADMINISTRATION	280	280	132,503	0	192,469	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	1,694	1,694	133,917	0	195,903	14.00
15.00	01500	PHARMACY	1,357	1,357	201,377	0	398,200	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,086	1,086	63,552	0	109,236	16.00
17.00	01700	SOCIAL SERVICE	0	0	101,088	0	90,456	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,787	6,787	1,234,697	0	1,751,921	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,223	3,223	565,942	0	1,550,281	54.00
60.00	06000	LABORATORY	2,530	2,530	487,415	0	1,133,868	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,211	1,211	166,019	0	676,575	65.00
66.00	06600	PHYSICAL THERAPY	3,795	3,795	66,242	0	980,316	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	157,330	67.00
68.00	06800	SPEECH PATHOLOGY	257	257	0	0	76,023	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	77,147	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,315,116	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,028	1,028	201,199	0	357,883	76.00
76.01	03950	WOUND CARE	139	139	0	0	8,914	76.01
76.97	07697	CARDIAC REHABILITATION	955	955	86,943	0	134,726	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,500	5,500	728,680	0	1,051,565	88.00
91.00	09100	EMERGENCY	2,165	2,165	1,021,060	0	2,455,200	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)	70,987	70,987	7,049,846	-2,802,851	14,818,356	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	3,200	3,200	35,651	0	113,345	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,183,074	238,593	1,333,172		2,802,851	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.947188	3.216103	0.188155		0.187711	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			2,568		182,161	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000362		0.012200	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: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/28/2024 7:33 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	39,800					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	981	1,073				8.00
9.00	00900	HOUSEKEEPING	605	0	35,014			9.00
10.00	01000	DIETARY	1,848	0	1,848	1,073		10.00
11.00	01100	CAFETERIA	1,159	0	1,159	0	5,226,285	11.00
13.00	01300	NURSING ADMINISTRATION	280	0	280	0	132,503	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	1,694	0	1,694	0	133,917	14.00
15.00	01500	PHARMACY	1,357	0	1,357	0	201,377	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,086	0	1,086	0	63,552	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	101,088	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,787	1,073	6,787	1,073	1,234,697	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,223	0	3,223	0	565,942	54.00
60.00	06000	LABORATORY	2,530	0	2,530	0	487,415	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,211	0	1,211	0	166,019	65.00
66.00	06600	PHYSICAL THERAPY	3,795	0	3,795	0	66,242	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	257	0	257	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	1,028	0	1,028	0	201,199	76.00
76.01	03950	WOUND CARE	139	0	139	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	955	0	955	0	86,943	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,500	0	5,500	0	728,680	88.00
91.00	09100	EMERGENCY	2,165	0	2,165	0	1,021,060	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)	36,600	1,073	35,014	1,073	5,190,634	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	3,200	0	0	0	35,651	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,594,679	127,328	475,235	320,337	207,664	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	40.067312	118.665424	13.572714	298.543336	0.039735	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	491,574	31,819	23,806	61,801	38,833	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	12.351106	29.654240	0.679899	57.596459	0.007430	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: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/28/2024 7:33 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	2,558,222					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	585,166				14.00
15.00	01500	PHARMACY	201,377	6,820	1,361,154			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	183	0	43,676,087		16.00
17.00	01700	SOCIAL SERVICE	101,088	0	0	0	1,073	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,234,697	27,889	0	1,959,780	1,073	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,151	0	14,546,038	0	54.00
60.00	06000	LABORATORY	0	290,574	0	10,227,688	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	11,887	0	1,307,108	0	65.00
66.00	06600	PHYSICAL THERAPY	0	10,147	0	4,923,222	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	443	0	644,467	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	216,543	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	139,168	0	171,849	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,340,058	4,210,716	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	402	0	501,901	0	76.00
76.01	03950	WOUND CARE	0	0	0	11,619	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	2,642	0	196,083	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	27,178	21,096	0	0	88.00
91.00	09100	EMERGENCY	1,021,060	45,003	0	4,759,073	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)	2,558,222	584,487	1,361,154	43,676,087	1,073	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	679	0	0	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	248,882	328,863	577,162	190,622	121,288	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.097287	0.562000	0.424024	0.004364	113.036347	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,394	57,971	89,427	36,809	2,382	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.004845	0.099068	0.065699	0.000843	2.219944	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-2 | Date/Time Prepared: 5/28/2024 7:33 am

		Description	Worksheet CODE	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		OP IV THERAPY	1	30.00	-235,609	7.00
8.00		OP IV THERAPY	1	64.00	235,609	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/28/2024 7:33 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	2,971,580		2,971,580	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,112,603		2,112,603	0	0	54.00
60.00	06000	LABORATORY	1,709,718		1,709,718	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	235,609		235,609	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	887,516	0	887,516	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,397,715	0	1,397,715	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	189,924	0	189,924	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	105,023	0	105,023	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	170,590		170,590	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,148,571		2,148,571	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	490,615		490,615	0	0	76.00
76.01	03950	WOUND CARE	18,094		18,094	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	217,038		217,038	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,597,148		1,597,148	0	0	88.00
91.00	09100	EMERGENCY	3,218,173		3,218,173	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	744,692		744,692		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,214,609	0	18,214,609	0	0	200.00
201.00		Less Observation Beds	744,692		744,692		0	201.00
202.00		Total (see instructions)	17,469,917	0	17,469,917	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/28/2024 7:33 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	836,382		836,382			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	365,943	14,180,095	14,546,038	0.145236	0.000000	54.00
60.00	06000	LABORATORY	527,665	9,700,023	10,227,688	0.167166	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	550,622	550,622	0.427896	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	105,840	1,201,268	1,307,108	0.678992	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	313,068	4,610,154	4,923,222	0.283902	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	210,903	433,564	644,467	0.294699	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	19,927	196,616	216,543	0.484998	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	77,470	94,379	171,849	0.992674	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	306,561	3,904,155	4,210,716	0.510263	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	501,901	501,901	0.977513	0.000000	76.00
76.01	03950	WOUND CARE	0	11,619	11,619	1.557277	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	196,083	196,083	1.106868	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	876,275	876,275			88.00
91.00	09100	EMERGENCY	161,564	4,597,509	4,759,073	0.676218	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	125,704	447,072	572,776	1.300145	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	3,051,027	41,501,335	44,552,362			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,051,027	41,501,335	44,552,362			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/28/2024 7:33 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			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
76.01	03950	WOUND CARE	0.000000		76.01
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		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: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/28/2024 7:33 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	308,907	14,546,038	0.021237	26,481	562	54.00
60.00	06000	LABORATORY	136,490	10,227,688	0.013345	58,611	782	60.00
64.00	06400	INTRAVENOUS THERAPY	0	550,622	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	50,815	1,307,108	0.038876	26,738	1,039	65.00
66.00	06600	PHYSICAL THERAPY	139,808	4,923,222	0.028398	11,768	334	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,506	644,467	0.003888	5,913	23	67.00
68.00	06800	SPEECH PATHOLOGY	9,384	216,543	0.043336	236	10	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,873	171,849	0.086547	11,274	976	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,635	4,210,716	0.025562	44,577	1,139	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	39,493	501,901	0.078687	0	0	76.00
76.01	03950	WOUND CARE	4,595	11,619	0.395473	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	33,493	196,083	0.170810	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	199,654	876,275	0.227844	0	0	88.00
91.00	09100	EMERGENCY	121,023	4,759,073	0.025430	2,830	72	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	89,192	572,776	0.155719	5,783	901	92.00
200.00		Total (lines 50 through 199)	1,257,868	43,715,980		194,211	5,838	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/28/2024 7:33 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.01	03950	WOUND CARE	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/28/2024 7:33 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,546,038	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	10,227,688	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	550,622	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,307,108	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,923,222	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	644,467	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	216,543	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	171,849	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,210,716	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	501,901	0.000000	76.00
76.01	03950	WOUND CARE	0	0	0	11,619	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	196,083	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	876,275	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	4,759,073	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	572,776	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	43,715,980		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/28/2024 7:33 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	26,481	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	58,611	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	26,738	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	11,768	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	5,913	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	236	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	11,274	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	44,577	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03950	WOUND CARE	0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	2,830	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	5,783	0	0	0	92.00
200.00		Total (lines 50 through 199)		194,211	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/28/2024 7:33 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145236	0	3,480,809	0	0	54.00
60.00	06000	LABORATORY	0.167166	0	2,412,780	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.427896	0	233,646	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.678992	0	277,560	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.283902	0	1,394,884	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294699	0	103,007	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.484998	0	43,621	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.992674	0	29,758	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.510263	0	2,231,740	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.977513	0	472,717	0	0	76.00
76.01	03950	WOUND CARE	1.557277	0	2,705	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	1.106868	0	103,831	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	0.676218	0	797,570	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.300145	0	203,701	0	0	92.00
200.00		Subtotal (see instructions)		0	11,788,329	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	11,788,329	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/28/2024 7:33 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				
54.00	05400	RADIOLOGY-DIAGNOSTIC	505,539	0		54.00
60.00	06000	LABORATORY	403,335	0		60.00
64.00	06400	INTRAVENOUS THERAPY	99,976	0		64.00
65.00	06500	RESPIRATORY THERAPY	188,461	0		65.00
66.00	06600	PHYSICAL THERAPY	396,010	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	30,356	0		67.00
68.00	06800	SPEECH PATHOLOGY	21,156	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29,540	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,138,774	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	462,087	0		76.00
76.01	03950	WOUND CARE	4,212	0		76.01
76.97	07697	CARDIAC REHABILITATION	114,927	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	539,331	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	264,841	0		92.00
200.00		Subtotal (see instructions)	4,198,545	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,198,545	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/28/2024 7:33 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)	1,427	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	610	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)	256	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	801	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	16	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	106	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)	478	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	208.70	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	208.70	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,971,580	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)	3,339	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,688,355	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,283,225	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)	1,283,225	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,103.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	222,986	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)	222,986	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/28/2024 7:33 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)	80,367	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)	303,353	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	1,005,540	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	1,005,540	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)	354	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,103.65	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	744,692	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/28/2024 7:33 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	355,905	2,971,580	0.119770	744,692	89,192	90.00
91.00	Nursing Program cost	0	2,971,580	0.000000	744,692	0	91.00
92.00	Allied health cost	0	2,971,580	0.000000	744,692	0	92.00
93.00	All other Medical Education	0	2,971,580	0.000000	744,692	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/28/2024 7:33 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		118,661		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145236	26,481	3,846	54.00
60.00	06000	LABORATORY	0.167166	58,611	9,798	60.00
64.00	06400	INTRAVENOUS THERAPY	0.427896	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.678992	26,738	18,155	65.00
66.00	06600	PHYSICAL THERAPY	0.283902	11,768	3,341	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294699	5,913	1,743	67.00
68.00	06800	SPEECH PATHOLOGY	0.484998	236	114	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.992674	11,274	11,191	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.510263	44,577	22,746	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.977513	0	0	76.00
76.01	03950	WOUND CARE	1.557277	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	1.106868	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.676218	2,830	1,914	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.300145	5,783	7,519	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		194,211	80,367	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)		194,211		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1306 | Component CCN: 14-Z306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/28/2024 7:33 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				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145236	17,419	2,530	54.00
60.00	06000	LABORATORY	0.167166	68,474	11,447	60.00
64.00	06400	INTRAVENOUS THERAPY	0.427896	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.678992	11,075	7,520	65.00
66.00	06600	PHYSICAL THERAPY	0.283902	161,916	45,968	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294699	114,727	33,810	67.00
68.00	06800	SPEECH PATHOLOGY	0.484998	10,529	5,107	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.992674	13,706	13,606	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.510263	99,137	50,586	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.977513	0	0	76.00
76.01	03950	WOUND CARE	1.557277	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	1.106868	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.676218	2,748	1,858	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.300145	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		499,731	172,432	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)		499,731		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part B Date/Time Prepared: 5/28/2024 7:33 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,198,545	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 including REH direct graduate medical education 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)	4,198,545	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)	4,240,530	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)	39,701	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,831,958	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,368,871	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	2,368,871	30.00
31.00	Primary payer payments	1,644	31.00
32.00	Subtotal (line 30 minus line 31)	2,367,227	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)	176,095	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	114,462	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	173,602	36.00
37.00	Subtotal (see instructions)	2,481,689	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,481,689	40.00
40.01	Sequestration adjustment (see instructions)	49,634	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	2,533,219	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)	-101,164	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1306	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/28/2024 7:33 am
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 5/28/2024 7:33 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		245,090		2,458,540	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	08/22/2023	9,405		0	3.01
3.02		12/15/2023	15,759	12/15/2023	170,382	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	08/22/2023	95,703	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)		25,164		74,679	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)		270,254		2,533,219	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		22,885		101,164	6.02
7.00	Total Medicare program liability (see instructions)		247,369		2,432,055	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: 14-1306 | Component CCN: 14-Z306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/28/2024 7:33 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		982,860		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	08/22/2023	129,097		0	3.01
3.02		12/15/2023	24,860		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)		153,957		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,136,817		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		15,419		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,152,236		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: 14-1306	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/28/2024 7:33 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: 14-1306 | Component CCN: 14-Z306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/28/2024 7:33 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)	1,015,595	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)	174,156	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	478	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,189,751	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,189,751	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,189,751	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	14,000	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,175,751	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,175,751	0	19.00
19.01	Sequestration adjustment (see instructions)	23,515	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	1,136,817	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)	15,419	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: 14-1306	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/28/2024 7:33 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	303,353	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)	303,353	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	306,387	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)	306,387	19.00
20.00	Deductibles (exclude professional component)	57,501	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	248,886	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	248,886	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	5,433	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	3,531	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	5,433	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	252,417	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)	252,417	30.00
30.01	Sequestration adjustment (see instructions)	5,048	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	270,254	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)	-22,885	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: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/28/2024 7:33 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,248,219	0	0	0	1.00
2.00	Temporary investments	646,410	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,676,800	0	0	0	4.00
5.00	Other receivable	14,364	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	286,741	0	0	0	7.00
8.00	Prepaid expenses	140,955	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)	8,013,489	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	177,500	0	0	0	12.00
13.00	Land improvements	1,976,502	0	0	0	13.00
14.00	Accumulated depreciation	-1,220,916	0	0	0	14.00
15.00	Buildings	27,519,159	0	0	0	15.00
16.00	Accumulated depreciation	-10,389,147	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	526,461	0	0	0	19.00
20.00	Accumulated depreciation	-192,912	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	2,773,843	0	0	0	23.00
24.00	Accumulated depreciation	-1,308,989	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	19,861,501	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	10,792,220	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	480,414	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	11,272,634	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	39,147,624	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	633,250	0	0	0	37.00
38.00	Salaries, wages, and fees payable	787,145	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	211,775	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	86,543	0	0	0	43.00
44.00	Other current liabilities	484,449	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,203,162	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	7,097,457	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	7,055	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,104,512	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	9,307,674	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	29,839,950				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)	29,839,950	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	39,147,624	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/28/2024 7:33 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		26,867,667		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,972,283				2.00
3.00	Total (sum of line 1 and line 2)		29,839,950		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		29,839,950		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)		29,839,950		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1306 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/28/2024 7:33 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,032,667		2,032,667	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,032,667		2,032,667	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)	2,032,667		2,032,667	17.00
18.00	Ancillary services	1,927,377	35,153,727	37,081,104	18.00
19.00	Outpatient services	162,682	4,561,610	4,724,292	19.00
20.00	RURAL HEALTH CLINIC	0	866,373	866,373	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,122,726	40,581,710	44,704,436	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		19,738,147		29.00
30.00	BAD DEBTS	802,676			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)		802,676		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		20,540,823		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1306	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/28/2024 7:33 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	44,704,436	1.00
2.00	Less contractual allowances and discounts on patients' accounts	22,886,962	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,817,474	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,540,823	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,276,651	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	3,264	6.00
7.00	Income from investments	293,084	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	111,744	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	23,705	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	62,021	16.00
17.00	Revenue from sale of drugs to other than patients	24,942	17.00
18.00	Revenue from sale of medical records and abstracts	3,934	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	1,172,938	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,695,632	25.00
26.00	Total (line 5 plus line 25)	2,972,283	26.00
27.00	GAIN/LOSS ON ASSET	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,972,283	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1306 | Component CCN: 14-8580 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/28/2024 7:33 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	268,435	0	268,435	0	268,435	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	169,046	0	169,046	0	169,046	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	166,466	0	166,466	0	166,466	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
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
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)	603,947	0	603,947	0	603,947	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	48,274	48,274	0	48,274	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	21,703	21,703	0	21,703	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	69,977	69,977	0	69,977	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	603,947	69,977	673,924	0	673,924	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	1,378	0	1,378	0	1,378	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)	1,378	0	1,378	0	1,378	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	2,368	2,368	0	2,368	29.00
30.00	Administrative Costs	123,355	8,036	131,391	0	131,391	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	123,355	10,404	133,759	0	133,759	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	728,680	80,381	809,061	0	809,061	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1306 | Component CCN: 14-8580 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/28/2024 7:33 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	268,435		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	169,046		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	166,466		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
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	603,947		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	48,274		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	21,703		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	69,977		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	673,924		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	1,378		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	1,378		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	2,368		29.00
30.00	Administrative Costs	0	131,391		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	133,759		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	809,061		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1306 | Component CCN: 14-8580 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/28/2024 7:33 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.53	2,002	4,200	2,226		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.31	2,532	2,100	2,751		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.84	4,534		4,977	4,977	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
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.84	4,534			4,977	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)					673,924	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,378	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					675,302	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.997959	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					133,759	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					788,087	15.00
16.00	Total overhead (sum of lines 14 and 15)					921,846	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					921,846	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					919,965	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,593,889	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1306 Component CCN: 14-8580	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/28/2024 7:33 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)		1,593,889	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		21,530	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,572,359	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,977	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		4,977	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		315.93	7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	438.03	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	315.93	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	774	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	244,530	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	244,530	16.00
16.01	Total program charges (see instructions)(from contractor's records)		145,845	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		16,511	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		27,683	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		162,134	16.04
16.05	Total program cost (see instructions)	0	189,817	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		14,179	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		23,031	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		189,817	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		9,529	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		199,346	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		199,346	26.00
26.01	Sequestration adjustment (see instructions)		3,987	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		215,798	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)		-20,439	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: 14-1306 | Component CCN: 14-8580 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/28/2024 7:33 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)	603,947	603,947	603,947	603,947	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000418	0.001019	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	252	615	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	5,545	2,691	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	5,797	3,306	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	673,924	673,924	673,924	673,924	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	919,965	919,965	919,965	919,965	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.008602	0.004906	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	7,914	4,513	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	13,711	7,819	0	0	10.00
11.00	Total number of injections/infusions (from your records)	25	61	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	548.44	128.18	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	12	23	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	6,581	2,948	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)		21,530	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)		9,529	16.00

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

Provider CCN: 14-1306 | Component CCN: 14-8580 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-5 | Date/Time Prepared: 5/28/2024 7:33 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		205,989	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		08/22/2023	9,809	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		9,809	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		215,798	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		20,439	6.02
7.00	Total Medicare program liability (see instructions)		195,359	7.00

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