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: 14-1333	Period: From 03/01/2022 To 02/28/2023	Worksheet S Parts I-III Date/Time Prepared: 7/27/2023 11:14 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 7/27/2023 Time: 11:14 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 SARAH D CULBERTSON (14-1333) for the cost reporting period beginning 03/01/2022 and ending 02/28/2023 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	Tammy Gadberry		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	Tammy Gadberry			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	60,331	1,009,153	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	63,940	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		37,233		0	10.00
200.00	TOTAL	0	124,271	1,046,386	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: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-2 Part I Date/Time Prepared: 7/27/2023 11:14 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 238 SOUTH CONGRESS	PO Box:			1.00
2.00	City: RUSHVILLE	State: IL	Zip Code: 62681	County: SCHUYLER	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	SARAH D CULBERTSON	141333	99914	1	05/01/2004	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SDCMH SWING BED- SNF	14Z333	99914		05/01/2004	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	ELMER HUGH TAYLOR CLINIC	143483	99914		10/01/2006	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)	03/01/2022	02/28/2023	20.00
21.00	Type of Control (see instructions)	11		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-2 Part I | Date/Time Prepared: 7/27/2023 11:14 am

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

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

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

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

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

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		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: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-2 Part I Date/Time Prepared: 7/27/2023 11:14 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: 14-1333	Period: From 03/01/2022 To 02/28/2023	Worksheet S-2 Part I Date/Time Prepared: 7/27/2023 11:14 am

				1.00		
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)					
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?			N		68.00
			1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)		N	N	0	71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
				1.00		
	Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00
	TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N		87.00
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments		
			1.00	2.00		
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.			0		88.00
		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge		
		1.00	2.00	3.00		
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		0		89.00
			V	XIX		
			1.00	2.00		
	Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00		97.00

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		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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)	Y		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	N	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
113.00	Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.				113.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-2 Part I | Date/Time Prepared: 7/27/2023 11:14 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	67,733	0	0	118.01

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-2 Part II | Date/Time Prepared: 7/27/2023 11:14 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/25/2022	Y	04/25/2022	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: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-2 Part II | Date/Time Prepared: 7/27/2023 11:14 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		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.	DAVID		MCCLUNG		41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	641-494-2144		DAVID.MCCLUNG@RSMUS.COM		43.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-3 Part I | Date/Time Prepared: 7/27/2023 11:14 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	22	8,030	5,482.00	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)		22	8,030	5,482.00	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)		22	8,030	5,482.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		22				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: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-3 Part I | Date/Time Prepared: 7/27/2023 11:14 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)	119	24	228			1.00
2.00	HMO and other (see instructions)	4	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	104	0	145			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	89			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	223	24	462			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)	223	24	462	0.00	113.18	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	2,420	271	12,700	0.00	17.01	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	130.19	27.00
28.00	Observation Bed Days		0	391			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: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-3 Part I | Date/Time Prepared: 7/27/2023 11:14 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	43	12	234	1.00
2.00	HMO and other (see instructions)			2	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	43	12	234	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	RHC (CONSOLIDATED)	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: 14-1333 | Component CCN: 14-3483 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-8 | Date/Time Prepared: 7/27/2023 11:14 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			238 S. CONGRESS		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	RUSHVILLE		IL	62681	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			08:00	17:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				Y	4	13.00
				Provider name		CCN	
				1.00		2.00	
14.00	RHC/FQHC name, CCN			COMMUNITY MEDICAL CLINIC		143484	14.00
14.01				ELMER HUGH TAYLOR CLINIC		143483	14.01
14.02				RUSHVILLE FAMILY PRACTICE		148578	14.02
14.03				COMMUNITY MEDICAL CLINIC OF TABLE GR		148585	14.03
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		SCHUYLER				2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1333
Component CCN: 14-3483

Period:
From 03/01/2022
To 02/28/2023

Worksheet S-8

Date/Time Prepared:
7/27/2023 11:14 am

RHC I | Cost

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

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet S-10 | Date/Time Prepared: 7/27/2023 11:14 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.474390	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,340,930	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	2,526,962	5.00
6.00	Medicaid charges	10,107,847	6.00
7.00	Medicaid cost (line 1 times line 6)	4,795,062	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	0	175	175	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	0	175	175	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	0	175	175	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,472,170	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	293,771	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	451,956	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,020,214	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	642,164	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	642,339	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	642,339	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A | Date/Time Prepared: 7/27/2023 11:14 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		620,598	620,598	39,567	660,165	1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME		130,619	130,619	4,616	135,235	1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME		28,389	28,389	2,432	30,821	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		197,427	197,427	19,294	216,721	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,391,367	3,391,367	0	3,391,367	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	87,687	330,370	418,057	0	418,057	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	447,420	1,162,887	1,610,307	0	1,610,307	5.04
5.05	00590	OTHER ADMIN. & GENERAL	756,835	1,489,561	2,246,396	-67,012	2,179,384	5.05
6.00	00600	MAINTENANCE & REPAIRS	180,832	113,808	294,640	0	294,640	6.00
7.00	00700	OPERATION OF PLANT	79,780	293,794	373,574	0	373,574	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	24,071	24,071	54,806	78,877	7.01
9.00	00900	HOUSEKEEPING	282,695	69,940	352,635	0	352,635	9.00
10.00	01000	DIETARY	354,244	227,042	581,286	0	581,286	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	272,136	313,798	585,934	0	585,934	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	327,142	258,491	585,633	0	585,633	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	299,734	56,744	356,478	0	356,478	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	698,142	339,676	1,037,818	0	1,037,818	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	173,311	261,161	434,472	0	434,472	50.00
53.00	05300	ANESTHESIOLOGY	0	8,170	8,170	0	8,170	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	559,967	519,201	1,079,168	34,824	1,113,992	54.00
60.00	06000	LABORATORY	519,809	960,894	1,480,703	24,071	1,504,774	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	32,848	32,848	0	32,848	62.00
65.00	06500	RESPIRATORY THERAPY	5,748	85,484	91,232	0	91,232	65.00
66.00	06600	PHYSICAL THERAPY	280,669	140,823	421,492	-141,961	279,531	66.00
67.00	06700	OCCUPATIONAL THERAPY	112,799	0	112,799	74,861	187,660	67.00
68.00	06800	SPEECH PATHOLOGY	59,478	3,751	63,229	67,100	130,329	68.00
69.00	06900	ELECTROCARDIOLOGY	92,261	141,217	233,478	0	233,478	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	114,692	114,692	0	114,692	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	699,867	699,867	1,721,988	2,421,855	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,949,009	472,920	2,421,929	-90,100	2,331,829	88.00
90.00	09000	CLINIC	436,942	2,616,674	3,053,616	-1,745,589	1,308,027	90.00
90.02	09002	GEROPSYCH	154,404	96,487	250,891	0	250,891	90.02
91.00	09100	EMERGENCY	697,760	2,792,832	3,490,592	0	3,490,592	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,828,804	17,995,603	26,824,407	-1,103	26,823,304	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	1,103	1,103	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	28,032	51,764	79,796	0	79,796	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	8,856,836	18,047,367	26,904,203	0	26,904,203	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A | Date/Time Prepared: 7/27/2023 11:14 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	0	660,165		1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	-300	134,935		1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	30,821		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-518	216,203		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-627,467	2,763,900		4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	-6,917	411,140		5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	-48,459	1,561,848		5.04
5.05	00590	OTHER ADMIN. & GENERAL	-68,772	2,110,612		5.05
6.00	00600	MAINTENANCE & REPAIRS	0	294,640		6.00
7.00	00700	OPERATION OF PLANT	-697	372,877		7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	78,877		7.01
9.00	00900	HOUSEKEEPING	0	352,635		9.00
10.00	01000	DIETARY	-64,481	516,805		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	585,934		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,212	584,421		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	356,478		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-97,575	940,243		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-219,200	215,272		50.00
53.00	05300	ANESTHESIOLOGY	0	8,170		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,113,992		54.00
60.00	06000	LABORATORY	0	1,504,774		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	32,848		62.00
65.00	06500	RESPIRATORY THERAPY	-82,800	8,432		65.00
66.00	06600	PHYSICAL THERAPY	0	279,531		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	187,660		67.00
68.00	06800	SPEECH PATHOLOGY	-1,838	128,491		68.00
69.00	06900	ELECTROCARDIOLOGY	-40,680	192,798		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	114,692		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,421,855		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-14,929	2,316,900		88.00
90.00	09000	CLINIC	-926,532	381,495		90.00
90.02	09002	GEROPSYCH	0	250,891		90.02
91.00	09100	EMERGENCY	-352,798	3,137,794		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,555,175	24,268,129		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	CULBERTSON GARDENS	0	1,103		194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0		194.01
194.02	07952	FOUNDATION	0	79,796		194.02
194.03	07953	OUTPATIENT MEALS	0	0		194.03
194.04	07954	VACANT SPACE	0	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,555,175	24,349,028		200.00

RECLASSIFICATIONS | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A-6 | Date/Time Prepared: 7/27/2023 11:14 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	65,909	1.00
2.00	CULBERTSON GARDENS	194.00	0	1,103	2.00
	TOTALS		0	67,012	
	C - RHC EXPENSES				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	34,824	0	1.00
2.00	LABORATORY	60.00	24,071	0	2.00
3.00	PLANT & HOUSEKEEPING-RHC	7.01	35,952	18,854	3.00
	TOTALS		94,847	18,854	
	D - THERAPY RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	45,769	29,092	1.00
2.00	SPEECH PATHOLOGY	68.00	41,024	26,076	2.00
	TOTALS		86,793	55,168	
	E - TO RECLASS PHYS TO RHC				
1.00	RURAL HEALTH CLINIC	88.00	17,974	5,627	1.00
	TOTALS		17,974	5,627	
	F - DRUG EXPENSE RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,721,988	1.00
	TOTALS		0	1,721,988	
500.00	Grand Total: Increases		199,614	1,868,649	500.00

RECLASSIFICATIONS | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A-6 | Date/Time Prepared: 7/27/2023 11:14 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PROPERTY INSURANCE						
1.00	OTHER ADMIN. & GENERAL	5.05	0	67,012	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	67,012			
	C - RHC EXPENSES						
1.00	RURAL HEALTH CLINIC	88.00	94,847	18,854	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		94,847	18,854			
	D - THERAPY RECLASS						
1.00	PHYSICAL THERAPY	66.00	86,793	55,168	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		86,793	55,168			
	E - TO RECLASS PHYS TO RHC						
1.00	CLINIC	90.00	17,974	5,627	0		1.00
	TOTALS		17,974	5,627			
	F - DRUG EXPENSE RECLASS						
1.00	CLINIC	90.00	0	1,721,988	0		1.00
	TOTALS		0	1,721,988			
500.00	Grand Total: Decreases		199,614	1,868,649			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A-7 Part I | Date/Time Prepared: 7/27/2023 11:14 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	408,368	0	0	0	0	1.00
2.00	Land Improvements	1,078,153	0	0	0	0	2.00
3.00	Buildings and Fixtures	8,800,369	2,396,838	0	2,396,838	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	5,374,199	0	0	0	0	5.00
6.00	Movable Equipment	7,083,139	112,573	0	112,573	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	22,744,228	2,509,411	0	2,509,411	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	22,744,228	2,509,411	0	2,509,411	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	408,368	0	1.00
2.00	Land Improvements	1,078,153	0	2.00
3.00	Buildings and Fixtures	11,197,207	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	5,374,199	0	5.00
6.00	Movable Equipment	7,195,712	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	25,253,639	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	25,253,639	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A-7 Part II | Date/Time Prepared: 7/27/2023 11:14 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	620,598	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	130,619	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	28,389	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	197,427	0	0	0	2.00
3.00	Total (sum of lines 1-2)	779,606	197,427	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	620,598		1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	130,619		1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	28,389		1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	197,427		2.00
3.00	Total (sum of lines 1-2)	0	977,033		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A-7 Part III | Date/Time Prepared: 7/27/2023 11:14 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	14,409,271	0	14,409,271	0.600338	39,567	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	1,680,869	0	1,680,869	0.070030	4,616	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	885,486	0	885,486	0.036892	2,432	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	7,026,337	0	7,026,337	0.292740	19,294	2.00
3.00	Total (sum of lines 1-2)	24,001,963	0	24,001,963	1.000000	65,909	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	39,567	620,598	0	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	0	4,616	130,319	0	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	0	2,432	28,389	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	19,294	-518	197,427	2.00
3.00	Total (sum of lines 1-2)	0	0	65,909	778,788	197,427	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	39,567	0	0	660,165	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	4,616	0	0	134,935	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	2,432	0	0	30,821	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	19,294	0	0	216,203	2.00
3.00	Total (sum of lines 1-2)	0	65,909	0	0	1,042,124	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A-8 | Date/Time Prepared: 7/27/2023 11:14 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-RHCS BLDG/MME (chapter 2)		0	NEW CAP REL COSTS-RHCS BLDG/MME	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-MED ARTS BLDG/MME (chapter 2)		0	NEW CAP REL COSTS-MED ARTS BLDG/MME	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	0	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-5,293	OTHER ADMIN. & GENERAL	5.05	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-359	OTHER ADMIN. & GENERAL	5.05	0	7.00
8.00	Television and radio service (chapter 21)	A	-697	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	-1,719,943			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-64,481	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,212	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	0	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-RHCS BLDG/MME		0	NEW CAP REL COSTS-RHCS BLDG/MME	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-MED ARTS BLDG/MME		0	NEW CAP REL COSTS-MED ARTS BLDG/MME	1.02	0	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A-8 | Date/Time Prepared: 7/27/2023 11:14 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	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	INTEREST INCOME	B	0	OTHER ADMIN. & GENERAL	5.05	0	33.00
33.01	MISCELLANEOUS INCOME	B	-932	OTHER ADMIN. & GENERAL	5.05	0	33.01
33.03	MARKETING SALARY EXPENSE	A	-21,695	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.03
33.04	MARKETING BENEFITS EXPENSE	A	-6,792	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	MARKETING OTHER EXPENSE	A	-48,525	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.05
33.06	MARKETING OTHER EXPENSE	A	-2,505	OTHER ADMIN. & GENERAL	5.05	0	33.06
33.07	MARKETING OTHER EXPENSE	A	-14,929	RURAL HEALTH CLINIC	88.00	0	33.07
33.08	MARKETING OTHER EXPENSE	A	-518	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09	LOBBYING PORTION OF DUES	A	-991	OTHER ADMIN. & GENERAL	5.05	0	33.09
33.10	HEALTHLINK ADMINISTRATIVE FEES	A	21,761	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.10
33.11	PART B PHYSICIAN BILLING SALARIES	A	-6,917	HOSPITAL BUSINESS OFFICE	5.02	0	33.11
33.12	PART B PHYSICIAN BILLING EMP BENEFIT	A	-2,165	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.14	PATIENT COLLECTION FEES	B	-58,208	OTHER ADMIN. & GENERAL	5.05	0	33.14
33.16	PROPERTY TAXES	A	-484	OTHER ADMIN. & GENERAL	5.05	0	33.16
33.17	IMRF CONTRIBUTION	A	-618,510	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.18	OPC RENT - CLINIC	B	-1,480	CLINIC	90.00	0	33.18
33.19	OPC RENT - RHC	B	-300	NEW CAP REL COSTS-RHCS BLDG/MME	1.01	9	33.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,555,175				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A-8-2 | Date/Time Prepared: 7/27/2023 11:14 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	50.00	OPERATING ROOM	219,200	219,200	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	72,168	0	72,168	0	0	2.00
3.00	60.00	LABORATORY	30,000	0	30,000	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	82,800	82,800	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	40,680	40,680	0	0	0	5.00
6.00	90.00	CLINIC	200,000	200,000	0	0	0	6.00
7.00	90.00	CLINIC	260,070	260,070	0	0	0	7.00
8.00	91.00	EMERGENCY	2,314,857	352,798	1,962,059	0	0	8.00
9.00	90.00	CLINIC	29,400	29,400	0	0	0	9.00
10.00	90.00	CLINIC	60,000	60,000	0	0	0	10.00
11.00	90.00	CLINIC	44,000	44,000	0	0	0	11.00
12.00	90.00	CLINIC	187,000	187,000	0	0	0	12.00
13.00	90.00	CLINIC	137,082	137,082	0	0	0	13.00
14.00	30.00	ADULTS & PEDIATRICS	97,575	97,575	0	0	0	14.00
15.00	90.00	CLINIC	7,500	7,500	0	0	0	15.00
16.00	68.00	SPEECH PATHOLOGY	1,838	1,838	0	0	0	16.00
200.00			3,784,170	1,719,943	2,064,227		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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	90.00	CLINIC	0	0	0	0	0	10.00
11.00	90.00	CLINIC	0	0	0	0	0	11.00
12.00	90.00	CLINIC	0	0	0	0	0	12.00
13.00	90.00	CLINIC	0	0	0	0	0	13.00
14.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	14.00
15.00	90.00	CLINIC	0	0	0	0	0	15.00
16.00	68.00	SPEECH PATHOLOGY	0	0	0	0	0	16.00
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	50.00	OPERATING ROOM	0	0	0	219,200		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	82,800		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	40,680		5.00
6.00	90.00	CLINIC	0	0	0	200,000		6.00
7.00	90.00	CLINIC	0	0	0	260,070		7.00
8.00	91.00	EMERGENCY	0	0	0	352,798		8.00
9.00	90.00	CLINIC	0	0	0	29,400		9.00
10.00	90.00	CLINIC	0	0	0	60,000		10.00
11.00	90.00	CLINIC	0	0	0	44,000		11.00
12.00	90.00	CLINIC	0	0	0	187,000		12.00
13.00	90.00	CLINIC	0	0	0	137,082		13.00
14.00	30.00	ADULTS & PEDIATRICS	0	0	0	97,575		14.00
15.00	90.00	CLINIC	0	0	0	7,500		15.00
16.00	68.00	SPEECH PATHOLOGY	0	0	0	1,838		16.00
200.00			0	0	0	1,719,943		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1333	Period: From 03/01/2022 To 02/28/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/27/2023 11:14 am

Physical Therapy — 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	0.00	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	949.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	109.25	87.40	65.55	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	43.70	43.70	32.78			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)	82,943	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)	82,943	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)	82,943	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)	82,943	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)	7,254	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)	7,254	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	7,254	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)	7,254	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: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 7/27/2023 11:14 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)	87.40	65.55	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)	82,943	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	7,254	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)	90,197	63.00
64.00	Total cost of outside supplier services (from your records)	70,081	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	7,254	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	7,254	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	0	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	0	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: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 7/27/2023 11:14 am

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					1	1.00
2.00	Line 1 multiplied by 15 hours per week					15	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					9	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					0.00	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	50.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	109.25	87.40	65.55	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	43.70	43.70	32.78			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)					4,370	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)					4,370	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)					4,370	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)					4,370	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)					393	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)					393	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)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					393	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)					393	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: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 7/27/2023 11:14 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)	87.40	65.55	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)	4,370	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	393	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)	4,763	63.00
64.00	Total cost of outside supplier services (from your records)	3,750	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	393	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	393	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	0	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	0	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: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B Part I Date/Time Prepared: 7/27/2023 11:14 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	NEW RHCS BLDG/MME	NEW MED ARTS BLDG/MME	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	660,165	660,165				1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	134,935	0	134,935			1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	30,821	0	0	30,821		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	216,203				216,203	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,763,900	0	0	0	0	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	411,140	0	0	0	0	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	1,561,848	39,390	0	0	12,900	5.04
5.05	00590	OTHER ADMIN. & GENERAL	2,110,612	63,965	0	0	20,948	5.05
6.00	00600	MAINTENANCE & REPAIRS	294,640	41,201	0	0	13,493	6.00
7.00	00700	OPERATION OF PLANT	372,877	0	0	0	0	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	78,877	0	0	0	0	7.01
9.00	00900	HOUSEKEEPING	352,635	24,721	0	0	8,096	9.00
10.00	01000	DIETARY	516,805	33,617	0	0	11,010	10.00
11.00	01100	CAFETERIA	0	11,485	0	0	3,761	11.00
13.00	01300	NURSING ADMINISTRATION	585,934	1,519	0	0	498	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	584,421	29,692	0	0	9,724	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	356,478	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	940,243	62,981	0	0	20,626	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	215,272	53,464	0	0	17,509	50.00
53.00	05300	ANESTHESIOLOGY	8,170	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,113,992	46,731	0	0	15,304	54.00
60.00	06000	LABORATORY	1,504,774	17,708	0	0	5,799	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	32,848	1,215	0	0	398	62.00
65.00	06500	RESPIRATORY THERAPY	8,432	6,770	0	0	2,217	65.00
66.00	06600	PHYSICAL THERAPY	279,531	28,184	0	0	9,230	66.00
67.00	06700	OCCUPATIONAL THERAPY	187,660	7,803	0	0	2,555	67.00
68.00	06800	SPEECH PATHOLOGY	128,491	2,856	0	0	935	68.00
69.00	06900	ELECTROCARDIOLOGY	192,798	1,823	0	0	597	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	114,692	9,504	0	0	3,113	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,421,855	10,112	0	0	3,312	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,316,900	0	134,935	30,821	0	88.00
90.00	09000	CLINIC	381,495	93,437	0	0	30,602	90.00
90.02	09002	GEROPSYCH	250,891	35,489	0	0	11,623	90.02
91.00	09100	EMERGENCY	3,137,794	36,498	0	0	11,953	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,268,129	660,165	134,935	30,821	216,203	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	1,103	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	79,796	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	24,349,028	660,165	134,935	30,821	216,203	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B Part I | Date/Time Prepared: 7/27/2023 11:14 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	HOSPITAL BUSINESS OFFICE	Subtotal	HOSPITAL ONLY ADMIN & GENERAL	Subtotal	
			4.00	5.02	5A.02	5.04	5A.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,763,900					4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	27,364	438,504				5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	139,624	0	1,753,762	1,753,762		5.04
5.05	00590	OTHER ADMIN. & GENERAL	236,181	0	2,431,706	188,739	2,620,445	5.05
6.00	00600	MAINTENANCE & REPAIRS	56,431	0	405,765	31,494	437,259	6.00
7.00	00700	OPERATION OF PLANT	24,896	0	397,773	30,874	428,647	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	11,219	0	90,096	6,993	97,089	7.01
9.00	00900	HOUSEKEEPING	88,219	0	473,671	36,764	510,435	9.00
10.00	01000	DIETARY	110,547	0	671,979	52,156	724,135	10.00
11.00	01100	CAFETERIA	0	0	15,246	1,183	16,429	11.00
13.00	01300	NURSING ADMINISTRATION	84,924	0	672,875	52,226	725,101	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	102,089	0	725,926	56,343	782,269	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	93,536	0	450,014	34,928	484,942	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	217,865	12,777	1,254,492	97,369	1,351,861	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,084	13,321	353,650	27,449	381,099	50.00
53.00	05300	ANESTHESIOLOGY	0	5,359	13,529	1,050	14,579	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	185,613	128,786	1,490,426	115,681	1,606,107	54.00
60.00	06000	LABORATORY	169,725	90,473	1,788,479	138,815	1,927,294	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,876	36,337	2,820	39,157	62.00
65.00	06500	RESPIRATORY THERAPY	1,794	337	19,550	1,517	21,067	65.00
66.00	06600	PHYSICAL THERAPY	60,502	10,203	387,650	30,088	417,738	66.00
67.00	06700	OCCUPATIONAL THERAPY	49,483	4,365	251,866	19,549	271,415	67.00
68.00	06800	SPEECH PATHOLOGY	31,363	3,913	167,558	13,005	180,563	68.00
69.00	06900	ELECTROCARDIOLOGY	28,791	19,832	243,841	18,926	262,767	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,666	128,975	10,011	138,986	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	76,903	2,512,182	194,986	2,707,168	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	584,227	18,624	3,085,507	239,485	3,324,992	88.00
90.00	09000	CLINIC	130,745	4,992	641,271	49,773	691,044	90.00
90.02	09002	GEROPSYCH	48,184	1,812	347,999	27,010	375,009	90.02
91.00	09100	EMERGENCY	217,746	43,265	3,447,256	267,570	3,714,826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,755,152	438,504	24,259,381	1,746,804	24,252,423	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	1,103	86	1,189	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	8,748	0	88,544	6,872	95,416	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments			0		0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,763,900	438,504	24,349,028	1,753,762	24,349,028	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B Part I | Date/Time Prepared: 7/27/2023 11:14 am

		Cost Center Description	OTHER ADMIN. & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	PLANT & HOUSEKEEPING-RHC	HOUSEKEEPING	
			5.05	6.00	7.00	7.01	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & GENERAL	2,620,445					5.05
6.00	00600	MAINTENANCE & REPAIRS	52,733	489,992				6.00
7.00	00700	OPERATION OF PLANT	51,694	0	480,341			7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	11,709	0	0	108,798		7.01
9.00	00900	HOUSEKEEPING	61,558	23,492	23,030	0	618,515	9.00
10.00	01000	DIETARY	87,330	31,947	31,318	0	42,357	10.00
11.00	01100	CAFETERIA	1,981	10,915	10,700	0	14,471	11.00
13.00	01300	NURSING ADMINISTRATION	87,446	1,444	1,415	0	1,914	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	94,341	28,216	27,661	0	37,411	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	58,484	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	163,033	59,851	58,673	0	79,355	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,960	50,808	49,807	0	67,364	50.00
53.00	05300	ANESTHESIOLOGY	1,758	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	193,695	44,409	43,535	0	58,881	54.00
60.00	06000	LABORATORY	232,430	16,828	16,497	0	22,312	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,722	1,155	1,132	0	1,531	62.00
65.00	06500	RESPIRATORY THERAPY	2,541	6,433	6,307	0	8,530	65.00
66.00	06600	PHYSICAL THERAPY	50,379	26,784	26,257	0	35,512	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,732	7,415	7,269	0	9,831	67.00
68.00	06800	SPEECH PATHOLOGY	21,776	2,714	2,661	0	3,599	68.00
69.00	06900	ELECTROCARDIOLOGY	31,689	1,732	1,698	0	2,297	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,762	9,032	8,854	0	11,975	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	326,482	9,609	9,420	0	12,741	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	400,991	0	0	108,798	0	88.00
90.00	09000	CLINIC	83,339	88,798	87,045	0	117,731	90.00
90.02	09002	GEROPSYCH	45,226	33,726	33,061	0	44,716	90.02
91.00	09100	EMERGENCY	448,004	34,684	34,001	0	45,987	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,608,795	489,992	480,341	108,798	618,515	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	143	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	11,507	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	2,620,445	489,992	480,341	108,798	618,515	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B Part I | Date/Time Prepared: 7/27/2023 11:14 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			10.00	11.00	13.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC						7.01
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	917,087					10.00
11.00	01100	CAFETERIA	756,493	810,989				11.00
13.00	01300	NURSING ADMINISTRATION	0	48,779	866,099			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	84,464	0	1,054,362		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	543,426	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	111,569	126,050	270,221	174,572	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	32,022	68,690	42,950	0	50.00
53.00	05300	ANESTHESIOLOGY	0	7,666	0	0	543,426	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	97,422	0	38,101	0	54.00
60.00	06000	LABORATORY	0	95,319	0	42,950	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,628	3,421	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	50,203	0	223,065	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,858	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,277	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	19,471	41,793	22,168	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	15,933	0	88.00
90.00	09000	CLINIC	0	69,403	148,762	212,674	0	90.00
90.02	09002	GEROPSYCH	0	31,547	67,624	0	0	90.02
91.00	09100	EMERGENCY	0	123,880	265,588	281,949	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	868,062	810,989	866,099	1,054,362	543,426	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	10,595	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	38,430	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	917,087	810,989	866,099	1,054,362	543,426	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B Part I | Date/Time Prepared: 7/27/2023 11:14 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME					1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.02	00592	HOSPITAL BUSINESS OFFICE					5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL					5.04
5.05	00590	OTHER ADMIN. & GENERAL					5.05
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC					7.01
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
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,395,185	0	2,395,185		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	738,700	0	738,700		50.00
53.00	05300	ANESTHESIOLOGY	567,429	0	567,429		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,082,150	0	2,082,150		54.00
60.00	06000	LABORATORY	2,353,630	0	2,353,630		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	47,697	0	47,697		62.00
65.00	06500	RESPIRATORY THERAPY	49,927	0	49,927		65.00
66.00	06600	PHYSICAL THERAPY	829,938	0	829,938		66.00
67.00	06700	OCCUPATIONAL THERAPY	343,520	0	343,520		67.00
68.00	06800	SPEECH PATHOLOGY	219,590	0	219,590		68.00
69.00	06900	ELECTROCARDIOLOGY	383,615	0	383,615		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	185,609	0	185,609		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,065,420	0	3,065,420		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	3,850,714	0	3,850,714		88.00
90.00	09000	CLINIC	1,498,796	0	1,498,796		90.00
90.02	09002	GEROPSYCH	630,909	0	630,909		90.02
91.00	09100	EMERGENCY	4,948,919	0	4,948,919		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,191,748	0	24,191,748		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	CULBERTSON GARDENS	11,927	0	11,927		194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0		194.01
194.02	07952	FOUNDATION	106,923	0	106,923		194.02
194.03	07953	OUTPATIENT MEALS	38,430	0	38,430		194.03
194.04	07954	VACANT SPACE	0	0	0		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	24,349,028	0	24,349,028		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B Part II | Date/Time Prepared: 7/27/2023 11:14 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	NEW RHCS BLDG/MME	NEW MED ARTS BLDG/MME	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	0	0	0	0	0	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	0	39,390	0	0	12,900	5.04
5.05	00590	OTHER ADMIN. & GENERAL	0	63,965	0	0	20,948	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	41,201	0	0	13,493	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	0	0	0	7.01
9.00	00900	HOUSEKEEPING	0	24,721	0	0	8,096	9.00
10.00	01000	DIETARY	0	33,617	0	0	11,010	10.00
11.00	01100	CAFETERIA	0	11,485	0	0	3,761	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,519	0	0	498	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,692	0	0	9,724	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	62,981	0	0	20,626	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	53,464	0	0	17,509	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	46,731	0	0	15,304	54.00
60.00	06000	LABORATORY	0	17,708	0	0	5,799	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,215	0	0	398	62.00
65.00	06500	RESPIRATORY THERAPY	0	6,770	0	0	2,217	65.00
66.00	06600	PHYSICAL THERAPY	0	28,184	0	0	9,230	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,803	0	0	2,555	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,856	0	0	935	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,823	0	0	597	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,504	0	0	3,113	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,112	0	0	3,312	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	134,935	30,821	0	88.00
90.00	09000	CLINIC	0	93,437	0	0	30,602	90.00
90.02	09002	GEROPSYCH	0	35,489	0	0	11,623	90.02
91.00	09100	EMERGENCY	0	36,498	0	0	11,953	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	660,165	134,935	30,821	216,203	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	660,165	134,935	30,821	216,203	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B Part II | Date/Time Prepared: 7/27/2023 11:14 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	HOSPITAL BUSINESS OFFICE	HOSPITAL ONLY ADMIN & GENERAL	OTHER ADMIN. & GENERAL	
			2A	4.00	5.02	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	0	0	0			5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	52,290	0	0	52,290		5.04
5.05	00590	OTHER ADMIN. & GENERAL	84,913	0	0	5,627	90,540	5.05
6.00	00600	MAINTENANCE & REPAIRS	54,694	0	0	939	1,822	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	920	1,786	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	0	208	405	7.01
9.00	00900	HOUSEKEEPING	32,817	0	0	1,096	2,127	9.00
10.00	01000	DIETARY	44,627	0	0	1,555	3,017	10.00
11.00	01100	CAFETERIA	15,246	0	0	35	68	11.00
13.00	01300	NURSING ADMINISTRATION	2,017	0	0	1,557	3,021	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	39,416	0	0	1,680	3,260	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	1,041	2,021	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	83,607	0	0	2,903	5,633	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	70,973	0	0	818	1,588	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	31	61	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,035	0	0	3,449	6,693	54.00
60.00	06000	LABORATORY	23,507	0	0	4,139	8,031	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,613	0	0	84	163	62.00
65.00	06500	RESPIRATORY THERAPY	8,987	0	0	45	88	65.00
66.00	06600	PHYSICAL THERAPY	37,414	0	0	897	1,741	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,358	0	0	583	1,131	67.00
68.00	06800	SPEECH PATHOLOGY	3,791	0	0	388	752	68.00
69.00	06900	ELECTROCARDIOLOGY	2,420	0	0	564	1,095	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,617	0	0	298	579	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,424	0	0	5,813	11,281	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	165,756	0	0	7,140	13,855	88.00
90.00	09000	CLINIC	124,039	0	0	1,484	2,880	90.00
90.02	09002	GEROPSYCH	47,112	0	0	805	1,563	90.02
91.00	09100	EMERGENCY	48,451	0	0	7,983	15,476	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,042,124	0	0	52,082	90,137	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	3	5	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	205	398	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,042,124	0	0	52,290	90,540	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B Part II | Date/Time Prepared: 7/27/2023 11:14 am

		Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	PLANT & HOUSEKEEPING-RHC	HOUSEKEEPING	DIETARY	
			6.00	7.00	7.01	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS	57,455					6.00
7.00	00700	OPERATION OF PLANT	0	2,706				7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	613			7.01
9.00	00900	HOUSEKEEPING	2,755	130	0	38,925		9.00
10.00	01000	DIETARY	3,746	176	0	2,666	55,787	10.00
11.00	01100	CAFETERIA	1,280	60	0	911	46,018	11.00
13.00	01300	NURSING ADMINISTRATION	169	8	0	120	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,309	156	0	2,354	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,018	331	0	4,994	6,787	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,958	281	0	4,239	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,207	245	0	3,706	0	54.00
60.00	06000	LABORATORY	1,973	93	0	1,404	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	135	6	0	96	0	62.00
65.00	06500	RESPIRATORY THERAPY	754	36	0	537	0	65.00
66.00	06600	PHYSICAL THERAPY	3,141	148	0	2,235	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	869	41	0	619	0	67.00
68.00	06800	SPEECH PATHOLOGY	318	15	0	226	0	68.00
69.00	06900	ELECTROCARDIOLOGY	203	10	0	145	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,059	50	0	754	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,127	53	0	802	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	613	0	0	88.00
90.00	09000	CLINIC	10,412	489	0	7,409	0	90.00
90.02	09002	GEROPSYCH	3,955	186	0	2,814	0	90.02
91.00	09100	EMERGENCY	4,067	192	0	2,894	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	57,455	2,706	613	38,925	52,805	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	644	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	2,338	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	57,455	2,706	613	38,925	55,787	202.00

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		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			11.00	13.00	16.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC						7.01
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	63,618					11.00
13.00	01300	NURSING ADMINISTRATION	3,826	10,718				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,626	0	56,801			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	3,062		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,890	3,344	9,405		133,912	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,512	850	2,314		89,533	50.00
53.00	05300	ANESTHESIOLOGY	601	0	0		693	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,642	0	2,053		91,030	54.00
60.00	06000	LABORATORY	7,477	0	2,314		48,938	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		2,097	62.00
65.00	06500	RESPIRATORY THERAPY	128	42	0		10,617	65.00
66.00	06600	PHYSICAL THERAPY	3,938	0	12,017		61,531	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,165	0	0		14,766	67.00
68.00	06800	SPEECH PATHOLOGY	649	0	0		6,139	68.00
69.00	06900	ELECTROCARDIOLOGY	1,527	517	1,194		7,675	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		15,357	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		32,500	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	858		188,222	88.00
90.00	09000	CLINIC	5,444	1,841	11,457		165,455	90.00
90.02	09002	GEROPSYCH	2,475	837	0		59,747	90.02
91.00	09100	EMERGENCY	9,718	3,287	15,189		107,257	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,618	10,718	56,801	0	1,035,469	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0		652	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0		0	194.01
194.02	07952	FOUNDATION	0	0	0		603	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0		2,338	194.03
194.04	07954	VACANT SPACE	0	0	0		0	194.04
200.00		Cross Foot Adjustments				3,062	3,062	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	63,618	10,718	56,801	3,062	1,042,124	202.00

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		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME				1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME				1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.02	00592	HOSPITAL BUSINESS OFFICE				5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL				5.04
5.05	00590	OTHER ADMIN. & GENERAL				5.05
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC				7.01
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
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	133,912		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	89,533		50.00
53.00	05300	ANESTHESIOLOGY	0	693		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	91,030		54.00
60.00	06000	LABORATORY	0	48,938		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,097		62.00
65.00	06500	RESPIRATORY THERAPY	0	10,617		65.00
66.00	06600	PHYSICAL THERAPY	0	61,531		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,766		67.00
68.00	06800	SPEECH PATHOLOGY	0	6,139		68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,675		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,357		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	32,500		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	188,222		88.00
90.00	09000	CLINIC	0	165,455		90.00
90.02	09002	GEROPSYCH	0	59,747		90.02
91.00	09100	EMERGENCY	0	107,257		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,035,469		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	CULBERTSON GARDENS	0	652		194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0		194.01
194.02	07952	FOUNDATION	0	603		194.02
194.03	07953	OUTPATIENT MEALS	0	2,338		194.03
194.04	07954	VACANT SPACE	0	0		194.04
200.00		Cross Foot Adjustments	0	3,062		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,042,124		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B-1 | Date/Time Prepared: 7/27/2023 11:14 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW RHCS BLDG/MME (SQUARE FEET)	NEW MED ARTS BLDG/MME (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	1.02	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	54,318					1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	0	13,300				1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	0	9,400			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				54,318		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	8,856,836	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	0	0	0	0	87,687	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	3,241	0	0	3,241	447,420	5.04
5.05	00590	OTHER ADMIN. & GENERAL	5,263	0	0	5,263	756,835	5.05
6.00	00600	MAINTENANCE & REPAIRS	3,390	0	0	3,390	180,832	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	79,780	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	0	0	35,952	7.01
9.00	00900	HOUSEKEEPING	2,034	0	0	2,034	282,695	9.00
10.00	01000	DIETARY	2,766	0	0	2,766	354,244	10.00
11.00	01100	CAFETERIA	945	0	0	945	0	11.00
13.00	01300	NURSING ADMINISTRATION	125	0	0	125	272,136	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,443	0	0	2,443	327,142	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	299,734	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,182	0	0	5,182	698,142	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,399	0	0	4,399	173,311	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,845	0	0	3,845	594,791	54.00
60.00	06000	LABORATORY	1,457	0	0	1,457	543,880	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	100	0	0	100	0	62.00
65.00	06500	RESPIRATORY THERAPY	557	0	0	557	5,748	65.00
66.00	06600	PHYSICAL THERAPY	2,319	0	0	2,319	193,876	66.00
67.00	06700	OCCUPATIONAL THERAPY	642	0	0	642	158,568	67.00
68.00	06800	SPEECH PATHOLOGY	235	0	0	235	100,502	68.00
69.00	06900	ELECTROCARDIOLOGY	150	0	0	150	92,261	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	782	0	0	782	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	832	0	0	832	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	13,300	9,400	0	1,872,136	88.00
90.00	09000	CLINIC	7,688	0	0	7,688	418,968	90.00
90.02	09002	GEROPSYCH	2,920	0	0	2,920	154,404	90.02
91.00	09100	EMERGENCY	3,003	0	0	3,003	697,760	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,318	13,300	9,400	54,318	8,828,804	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	28,032	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	660,165	134,935	30,821	216,203	2,763,900	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.153706	10.145489	3.278830	3.980320	0.312064	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B-1 | Date/Time Prepared: 7/27/2023 11:14 am

		Cost Center Description	HOSPITAL BUSINESS OFFICE (GROSS CHARGES)	Reconciliation	HOSPITAL ONLY ADMIN & GENERAL (ACCUM. COST)	Reconciliation	OTHER ADMIN. & GENERAL (ACCUM. COST)	
			5.02	5A.04	5.04	5A.05	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	50,995,492					5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	0	-1,753,762	22,595,266			5.04
5.05	00590	OTHER ADMIN. & GENERAL	0	0	2,431,706	-2,620,445	21,728,583	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	405,765	0	437,259	6.00
7.00	00700	OPERATION OF PLANT	0	0	397,773	0	428,647	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	90,096	0	97,089	7.01
9.00	00900	HOUSEKEEPING	0	0	473,671	0	510,435	9.00
10.00	01000	DIETARY	0	0	671,979	0	724,135	10.00
11.00	01100	CAFETERIA	0	0	15,246	0	16,429	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	672,875	0	725,101	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	725,926	0	782,269	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	450,014	0	484,942	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,485,889	0	1,254,492	0	1,351,861	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,549,101	0	353,650	0	381,099	50.00
53.00	05300	ANESTHESIOLOGY	623,244	0	13,529	0	14,579	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,977,526	0	1,490,426	0	1,606,107	54.00
60.00	06000	LABORATORY	10,521,390	0	1,788,479	0	1,927,294	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	218,206	0	36,337	0	39,157	62.00
65.00	06500	RESPIRATORY THERAPY	39,193	0	19,550	0	21,067	65.00
66.00	06600	PHYSICAL THERAPY	1,186,557	0	387,650	0	417,738	66.00
67.00	06700	OCCUPATIONAL THERAPY	507,644	0	251,866	0	271,415	67.00
68.00	06800	SPEECH PATHOLOGY	455,017	0	167,558	0	180,563	68.00
69.00	06900	ELECTROCARDIOLOGY	2,306,345	0	243,841	0	262,767	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	193,768	0	128,975	0	138,986	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,943,198	0	2,512,182	0	2,707,168	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,165,885	0	3,085,507	0	3,324,992	88.00
90.00	09000	CLINIC	580,495	0	641,271	0	691,044	90.00
90.02	09002	GEROPSYCH	210,666	0	347,999	0	375,009	90.02
91.00	09100	EMERGENCY	5,031,368	0	3,447,256	0	3,714,826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,995,492	-1,753,762	22,505,619	-2,620,445	21,631,978	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	1,103	0	1,189	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	88,544	0	95,416	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	438,504		1,753,762		2,620,445	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.008599		0.077616		0.120599	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		52,290		90,540	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.002314		0.004167	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: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B-1 | Date/Time Prepared: 7/27/2023 11:14 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	PLANT & HOUSEKEEPING-RHC (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	7.01	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS	42,424					6.00
7.00	00700	OPERATION OF PLANT	0	42,424				7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	13,300			7.01
9.00	00900	HOUSEKEEPING	2,034	2,034	0	40,390		9.00
10.00	01000	DIETARY	2,766	2,766	0	2,766	24,150	10.00
11.00	01100	CAFETERIA	945	945	0	945	19,921	11.00
13.00	01300	NURSING ADMINISTRATION	125	125	0	125	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,443	2,443	0	2,443	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,182	5,182	0	5,182	2,938	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,399	4,399	0	4,399	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,845	3,845	0	3,845	0	54.00
60.00	06000	LABORATORY	1,457	1,457	0	1,457	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	100	100	0	100	0	62.00
65.00	06500	RESPIRATORY THERAPY	557	557	0	557	0	65.00
66.00	06600	PHYSICAL THERAPY	2,319	2,319	0	2,319	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	642	642	0	642	0	67.00
68.00	06800	SPEECH PATHOLOGY	235	235	0	235	0	68.00
69.00	06900	ELECTROCARDIOLOGY	150	150	0	150	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	782	782	0	782	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	832	832	0	832	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	13,300	0	0	88.00
90.00	09000	CLINIC	7,688	7,688	0	7,688	0	90.00
90.02	09002	GEROPSYCH	2,920	2,920	0	2,920	0	90.02
91.00	09100	EMERGENCY	3,003	3,003	0	3,003	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,424	42,424	13,300	40,390	22,859	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	279	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	1,012	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	489,992	480,341	108,798	618,515	917,087	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.549877	11.322388	8.180301	15.313568	37.974617	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	57,455	2,706	613	38,925	55,787	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.354304	0.063785	0.046090	0.963729	2.310021	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: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet B-1 | Date/Time Prepared: 7/27/2023 11:14 am

		Cost Center Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRS ING)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			11.00	13.00	16.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC						7.01
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	11,954					11.00
13.00	01300	NURSING ADMINISTRATION	719	65,818				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,245	0	1,522			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,858	20,535	252	0		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	472	5,220	62	0		50.00
53.00	05300	ANESTHESIOLOGY	113	0	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,436	0	55	0		54.00
60.00	06000	LABORATORY	1,405	0	62	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	24	260	0	0		65.00
66.00	06600	PHYSICAL THERAPY	740	0	322	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	219	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	122	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	287	3,176	32	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	23	0		88.00
90.00	09000	CLINIC	1,023	11,305	307	0		90.00
90.02	09002	GEROPSYCH	465	5,139	0	0		90.02
91.00	09100	EMERGENCY	1,826	20,183	407	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,954	65,818	1,522	100		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0		194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0		194.01
194.02	07952	FOUNDATION	0	0	0	0		194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0		194.03
194.04	07954	VACANT SPACE	0	0	0	0		194.04
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)	810,989	866,099	1,054,362	543,426		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	67.842480	13.158999	692.747700	5,434.260000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	63,618	10,718	56,801	3,062		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.321901	0.162843	37.319974	30.620000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet C Part I Date/Time Prepared: 7/27/2023 11:14 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	2,395,185		2,395,185	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	738,700		738,700	0	0	50.00
53.00	05300	ANESTHESIOLOGY	567,429		567,429	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,082,150		2,082,150	0	0	54.00
60.00	06000	LABORATORY	2,353,630		2,353,630	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	47,697		47,697	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	49,927	0	49,927	0	0	65.00
66.00	06600	PHYSICAL THERAPY	829,938	0	829,938	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	343,520	0	343,520	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	219,590	0	219,590	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	383,615		383,615	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	185,609		185,609	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,065,420		3,065,420	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,850,714		3,850,714	0	0	88.00
90.00	09000	CLINIC	1,498,796		1,498,796	0	0	90.00
90.02	09002	GEROPSYCH	630,909		630,909	0	0	90.02
91.00	09100	EMERGENCY	4,948,919		4,948,919	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,216,769		1,216,769		0	92.00
200.00		Subtotal (see instructions)	25,408,517	0	25,408,517	0	0	200.00
201.00		Less Observation Beds	1,216,769		1,216,769		0	201.00
202.00		Total (see instructions)	24,191,748	0	24,191,748	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet C Part I Date/Time Prepared: 7/27/2023 11:14 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	597,559		597,559			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,549,101	1,549,101	0.476857	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	623,244	623,244	0.910444	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,999	14,923,527	14,977,526	0.139018	0.000000	54.00
60.00	06000	LABORATORY	276,009	10,245,381	10,521,390	0.223700	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	21,540	196,666	218,206	0.218587	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	39,193	39,193	1.273875	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	97,442	1,089,115	1,186,557	0.699451	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	73,009	434,635	507,644	0.676695	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	12,339	442,678	455,017	0.482597	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	25,814	2,280,531	2,306,345	0.166330	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	81,678	112,090	193,768	0.957893	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	350,255	8,592,943	8,943,198	0.342766	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,165,885	2,165,885			88.00
90.00	09000	CLINIC	761	579,734	580,495	2.581927	0.000000	90.00
90.02	09002	GEROPSYCH	0	210,666	210,666	2.994831	0.000000	90.02
91.00	09100	EMERGENCY	6,496	5,024,872	5,031,368	0.983613	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,412	883,918	888,330	1.369726	0.000000	92.00
200.00		Subtotal (see instructions)	1,601,313	49,394,179	50,995,492			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,601,313	49,394,179	50,995,492			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet C Part I Date/Time Prepared: 7/27/2023 11:14 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.000000
53.00	05300	ANESTHESIOLOGY	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000
60.00	06000	LABORATORY	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000
65.00	06500	RESPIRATORY THERAPY	0.000000
66.00	06600	PHYSICAL THERAPY	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0.000000
68.00	06800	SPEECH PATHOLOGY	0.000000
69.00	06900	ELECTROCARDIOLOGY	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000
		OUTPATIENT SERVICE COST CENTERS	
88.00	08800	RURAL HEALTH CLINIC	
90.00	09000	CLINIC	0.000000
90.02	09002	GEROPSYCH	0.000000
91.00	09100	EMERGENCY	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet C Part I Date/Time Prepared: 7/27/2023 11:14 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,395,185		2,395,185	0	2,395,185	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	738,700		738,700	0	738,700	50.00
53.00	05300	ANESTHESIOLOGY	567,429		567,429	0	567,429	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,082,150		2,082,150	0	2,082,150	54.00
60.00	06000	LABORATORY	2,353,630		2,353,630	0	2,353,630	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	47,697		47,697	0	47,697	62.00
65.00	06500	RESPIRATORY THERAPY	49,927	0	49,927	0	49,927	65.00
66.00	06600	PHYSICAL THERAPY	829,938	0	829,938	0	829,938	66.00
67.00	06700	OCCUPATIONAL THERAPY	343,520	0	343,520	0	343,520	67.00
68.00	06800	SPEECH PATHOLOGY	219,590	0	219,590	0	219,590	68.00
69.00	06900	ELECTROCARDIOLOGY	383,615		383,615	0	383,615	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	185,609		185,609	0	185,609	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,065,420		3,065,420	0	3,065,420	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,850,714		3,850,714	0	3,850,714	88.00
90.00	09000	CLINIC	1,498,796		1,498,796	0	1,498,796	90.00
90.02	09002	GEROPSYCH	630,909		630,909	0	630,909	90.02
91.00	09100	EMERGENCY	4,948,919		4,948,919	0	4,948,919	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,216,769		1,216,769		1,216,769	92.00
200.00		Subtotal (see instructions)	25,408,517	0	25,408,517	0	25,408,517	200.00
201.00		Less Observation Beds	1,216,769		1,216,769		1,216,769	201.00
202.00		Total (see instructions)	24,191,748	0	24,191,748	0	24,191,748	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet C Part I Date/Time Prepared: 7/27/2023 11:14 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	597,559		597,559			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,549,101	1,549,101	0.476857	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	623,244	623,244	0.910444	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,999	14,923,527	14,977,526	0.139018	0.000000	54.00
60.00	06000	LABORATORY	276,009	10,245,381	10,521,390	0.223700	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	21,540	196,666	218,206	0.218587	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	39,193	39,193	1.273875	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	97,442	1,089,115	1,186,557	0.699451	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	73,009	434,635	507,644	0.676695	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	12,339	442,678	455,017	0.482597	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	25,814	2,280,531	2,306,345	0.166330	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	81,678	112,090	193,768	0.957893	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	350,255	8,592,943	8,943,198	0.342766	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,165,885	2,165,885	1.777894	0.000000	88.00
90.00	09000	CLINIC	761	579,734	580,495	2.581927	0.000000	90.00
90.02	09002	GEROPSYCH	0	210,666	210,666	2.994831	0.000000	90.02
91.00	09100	EMERGENCY	6,496	5,024,872	5,031,368	0.983613	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,412	883,918	888,330	1.369726	0.000000	92.00
200.00		Subtotal (see instructions)	1,601,313	49,394,179	50,995,492			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,601,313	49,394,179	50,995,492			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet C Part I Date/Time Prepared: 7/27/2023 11:14 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.000000
53.00	05300	ANESTHESIOLOGY	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000
60.00	06000	LABORATORY	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000
65.00	06500	RESPIRATORY THERAPY	0.000000
66.00	06600	PHYSICAL THERAPY	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0.000000
68.00	06800	SPEECH PATHOLOGY	0.000000
69.00	06900	ELECTROCARDIOLOGY	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000
		OUTPATIENT SERVICE COST CENTERS	
88.00	08800	RURAL HEALTH CLINIC	0.000000
90.00	09000	CLINIC	0.000000
90.02	09002	GEROPSYCH	0.000000
91.00	09100	EMERGENCY	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

30.00		30.00
50.00		50.00
53.00		53.00
54.00		54.00
60.00		60.00
62.00		62.00
65.00		65.00
66.00		66.00
67.00		67.00
68.00		68.00
69.00		69.00
71.00		71.00
72.00		72.00
73.00		73.00
88.00		88.00
90.00		90.00
90.02		90.02
91.00		91.00
92.00		92.00
200.00		200.00
201.00		201.00
202.00		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part II Date/Time Prepared: 7/27/2023 11:14 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	89,533	1,549,101	0.057797	0	0	50.00
53.00	05300	ANESTHESIOLOGY	693	623,244	0.001112	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	91,030	14,977,526	0.006078	22,966	140	54.00
60.00	06000	LABORATORY	48,938	10,521,390	0.004651	70,533	328	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,097	218,206	0.009610	5,034	48	62.00
65.00	06500	RESPIRATORY THERAPY	10,617	39,193	0.270890	0	0	65.00
66.00	06600	PHYSICAL THERAPY	61,531	1,186,557	0.051857	9,969	517	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,766	507,644	0.029087	7,577	220	67.00
68.00	06800	SPEECH PATHOLOGY	6,139	455,017	0.013492	2,363	32	68.00
69.00	06900	ELECTROCARDIOLOGY	7,675	2,306,345	0.003328	15,689	52	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,357	193,768	0.079255	42,335	3,355	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,500	8,943,198	0.003634	125,911	458	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	188,222	2,165,885	0.086903	0	0	88.00
90.00	09000	CLINIC	165,455	580,495	0.285024	0	0	90.00
90.02	09002	GEROPSYCH	59,747	210,666	0.283610	0	0	90.02
91.00	09100	EMERGENCY	107,257	5,031,368	0.021318	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	68,028	888,330	0.076580	66	5	92.00
200.00		Total (lines 50 through 199)	969,585	50,397,933		302,443	5,155	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part IV | Date/Time Prepared: 7/27/2023 11:14 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	543,426	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09002	GEROPSYCH	0	0	0	0	0	90.02
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)	543,426	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part IV | Date/Time Prepared: 7/27/2023 11:14 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,549,101	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	543,426	0	623,244	0.871931	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,977,526	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	10,521,390	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	218,206	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	39,193	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,186,557	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	507,644	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	455,017	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,306,345	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	193,768	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,943,198	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,165,885	0.000000	88.00
90.00	09000	CLINIC	0	0	0	580,495	0.000000	90.00
90.02	09002	GEROPSYCH	0	0	0	210,666	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	5,031,368	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	888,330	0.000000	92.00
200.00		Total (lines 50 through 199)	0	543,426	0	50,397,933		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part IV | Date/Time Prepared: 7/27/2023 11:14 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	22,966	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	70,533	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	5,034	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	9,969	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	7,577	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,363	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	15,689	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	42,335	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	125,911	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.02	09002	GEROPSYCH	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	66	0	0	0	92.00
200.00		Total (lines 50 through 199)		302,443	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part V Date/Time Prepared: 7/27/2023 11:14 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.476857	0	468,966	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.910444	0	174,596	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139018	0	4,512,986	2	0	54.00
60.00	06000	LABORATORY	0.223700	0	2,842,227	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.218587	0	46,198	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1.273875	0	22,544	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.699451	0	327,168	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.676695	0	33,444	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.482597	0	19,555	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.166330	0	937,528	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.957893	0	47,619	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.342766	0	3,552,052	941	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	2.581927	0	445,107	6,093	0	90.00
90.02	09002	GEROPSYCH	2.994831	0	208,994	0	0	90.02
91.00	09100	EMERGENCY	0.983613	0	1,223,650	559	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.369726	0	304,064	71	0	92.00
200.00		Subtotal (see instructions)		0	15,166,698	7,666	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	15,166,698	7,666	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part V Date/Time Prepared: 7/27/2023 11:14 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	223,630	0		50.00
53.00	05300	ANESTHESIOLOGY	158,960	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	627,386	0		54.00
60.00	06000	LABORATORY	635,806	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	10,098	0		62.00
65.00	06500	RESPIRATORY THERAPY	28,718	0		65.00
66.00	06600	PHYSICAL THERAPY	228,838	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	22,631	0		67.00
68.00	06800	SPEECH PATHOLOGY	9,437	0		68.00
69.00	06900	ELECTROCARDIOLOGY	155,939	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	45,614	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,217,523	323		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	1,149,234	15,732		90.00
90.02	09002	GEROPSYCH	625,902	0		90.02
91.00	09100	EMERGENCY	1,203,598	550		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	416,484	97		92.00
200.00		Subtotal (see instructions)	6,759,798	16,702		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,759,798	16,702		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1333 | Component CCN: 14-Z333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part IV | Date/Time Prepared: 7/27/2023 11:14 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	543,426	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09002	GEROPSYCH	0	0	0	0	0	90.02
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)	543,426	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1333 | Component CCN: 14-Z333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part IV | Date/Time Prepared: 7/27/2023 11:14 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,549,101	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	543,426	0	623,244	0.871931	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,977,526	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	10,521,390	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	218,206	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	39,193	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,186,557	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	507,644	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	455,017	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,306,345	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	193,768	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,943,198	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,165,885	0.000000	88.00
90.00	09000	CLINIC	0	0	0	580,495	0.000000	90.00
90.02	09002	GEROPSYCH	0	0	0	210,666	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	5,031,368	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	888,330	0.000000	92.00
200.00		Total (lines 50 through 199)	0	543,426	0	50,397,933		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1333 | Component CCN: 14-Z333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part IV | Date/Time Prepared: 7/27/2023 11:14 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	6,591	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	12,652	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	5,746	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	37,737	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	28,880	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	4,379	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,833	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	29,655	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.02	09002	GEROPSYCH	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		127,473	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1333 | Component CCN: 14-Z333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part V Date/Time Prepared: 7/27/2023 11:14 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.476857	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.910444	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139018	0	0	0	0	54.00
60.00	06000	LABORATORY	0.223700	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.218587	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1.273875	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.699451	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.676695	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.482597	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.166330	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.957893	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.342766	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	2.581927	0	0	0	0	90.00
90.02	09002	GEROPSYCH	2.994831	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.983613	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.369726	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1333 | Component CCN: 14-Z333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D Part V | Date/Time Prepared: 7/27/2023 11:14 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0	0		90.00
90.02	09002	GEROPSYCH	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D-1 | Date/Time Prepared: 7/27/2023 11:14 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)	853	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	619	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)	228	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	121	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)	24	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	74	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)	15	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	119	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)	87	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)	17	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	201.56	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	183.15	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,395,185	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)	14,915	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)	2,747	25.00
26.00	Total swing-bed cost (see instructions)	468,893	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,926,292	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)	1,926,292	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	3,111.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	370,321	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)	370,321	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D-1 | Date/Time Prepared: 7/27/2023 11:14 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)	119,721	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)	490,042	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)	270,739	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	52,903	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	323,642	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)	391	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,111.94	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,216,769	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D-1 | Date/Time Prepared: 7/27/2023 11:14 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	133,912	2,395,185	0.055909	1,216,769	68,028	90.00
91.00	Nursing Program cost	0	2,395,185	0.000000	1,216,769	0	91.00
92.00	Allied health cost	0	2,395,185	0.000000	1,216,769	0	92.00
93.00	All other Medical Education	0	2,395,185	0.000000	1,216,769	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D-3 | Date/Time Prepared: 7/27/2023 11:14 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		215,131		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.476857	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.910444	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139018	22,966	3,193	54.00
60.00	06000	LABORATORY	0.223700	70,533	15,778	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.218587	5,034	1,100	62.00
65.00	06500	RESPIRATORY THERAPY	1.273875	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.699451	9,969	6,973	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.676695	7,577	5,127	67.00
68.00	06800	SPEECH PATHOLOGY	0.482597	2,363	1,140	68.00
69.00	06900	ELECTROCARDIOLOGY	0.166330	15,689	2,610	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.957893	42,335	40,552	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.342766	125,911	43,158	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	2.581927	0	0	90.00
90.02	09002	GEROPSYCH	2.994831	0	0	90.02
91.00	09100	EMERGENCY	0.983613	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.369726	66	90	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		302,443	119,721	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)		302,443		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet D-3

Component CCN: 14-Z333 | Date/Time Prepared: 7/27/2023 11:14 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.476857	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.910444	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139018	6,591	916	54.00
60.00	06000	LABORATORY	0.223700	12,652	2,830	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.218587	5,746	1,256	62.00
65.00	06500	RESPIRATORY THERAPY	1.273875	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.699451	37,737	26,395	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.676695	28,880	19,543	67.00
68.00	06800	SPEECH PATHOLOGY	0.482597	4,379	2,113	68.00
69.00	06900	ELECTROCARDIOLOGY	0.166330	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.957893	1,833	1,756	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.342766	29,655	10,165	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	2.581927	0	0	90.00
90.02	09002	GEROPSYCH	2.994831	0	0	90.02
91.00	09100	EMERGENCY	0.983613	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.369726	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		127,473	64,974	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)		127,473		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1333	Period: From 03/01/2022 To 02/28/2023	Worksheet E Part B Date/Time Prepared: 7/27/2023 11:14 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,776,500	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,776,500	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)	6,844,265	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)	40,277	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,447,959	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	4,356,029	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	4,356,029	30.00
31.00	Primary payer payments	128	31.00
32.00	Subtotal (line 30 minus line 31)	4,355,901	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)	414,076	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	269,149	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	414,076	36.00
37.00	Subtotal (see instructions)	4,625,050	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,625,050	40.00
40.01	Sequestration adjustment (see instructions)	73,076	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		40.03
41.00	Interim payments	3,542,821	41.00
41.01	Interim payments-PARHM or CHART		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	1,009,153	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1333	Period: From 03/01/2022 To 02/28/2023	Worksheet E Part B Date/Time Prepared: 7/27/2023 11:14 am
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet E-1 Part I | Date/Time Prepared: 7/27/2023 11:14 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		362,824		3,542,821	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	11/30/2022	27,000		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		27,000		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)		389,824		3,542,821	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		60,331		1,009,153	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		450,155		4,551,974	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: 14-1333 | Component CCN: 14-Z333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet E-1 Part I | Date/Time Prepared: 7/27/2023 11:14 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		322,361		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		322,361		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		63,940		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		386,301		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: 14-1333	Period: From 03/01/2022 To 02/28/2023	Worksheet E-1 Part II Date/Time Prepared: 7/27/2023 11:14 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: 14-1333 | Component CCN: 14-Z333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet E-2 | Date/Time Prepared: 7/27/2023 11:14 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)	326,878	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)	65,624	0	3.00
3.01	Nursing and allied health payment-PARHM or CHART (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	104	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)	392,502	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	392,502	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)	392,502	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	392,502	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)	392,502	0	19.00
19.01	Sequestration adjustment (see instructions)	6,201	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM or CHART pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	322,361	0	20.00
20.01	Interim payments-PARHM or CHART			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM or CHART (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)	63,940	0	22.00
22.01	Balance due provider/program-PARHM or CHART (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: 14-1333	Period: From 03/01/2022 To 02/28/2023	Worksheet E-3 Part V Date/Time Prepared: 7/27/2023 11:14 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	490,042	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)	490,042	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	494,942	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)	494,942	19.00
20.00	Deductibles (exclude professional component)	46,944	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	447,998	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	447,998	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	14,435	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	9,383	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	14,435	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	457,381	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)	457,381	30.00
30.01	Sequestration adjustment (see instructions)	7,226	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM or CHART		30.03
31.00	Interim payments	389,824	31.00
31.01	Interim payments-PARHM or CHART		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM or CHART (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	60,331	33.00
33.01	Balance due provider/program-PARHM or CHART (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: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet G | Date/Time Prepared: 7/27/2023 11:14 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	20,013,522	0	0	0	1.00
2.00	Temporary investments	169,024	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,672,733	0	0	0	4.00
5.00	Other receivable	1,016,565	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	680,393	0	0	0	7.00
8.00	Prepaid expenses	141,527	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)	25,693,764	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	408,368	0	0	0	12.00
13.00	Land improvements	1,078,269	0	0	0	13.00
14.00	Accumulated depreciation	-970,510	0	0	0	14.00
15.00	Buildings	11,282,537	0	0	0	15.00
16.00	Accumulated depreciation	-4,863,388	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	12,557,910	0	0	0	19.00
20.00	Accumulated depreciation	-10,725,999	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	8,767,187	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	6,740,625	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	2,767,983	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,508,608	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	43,969,559	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,037,978	0	0	0	37.00
38.00	Salaries, wages, and fees payable	697,959	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	735,732	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,471,669	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	3,280,983	0	0	0	48.00
49.00	Other long term liabilities	1,472,211	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,753,194	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,224,863	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	36,744,696				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)	36,744,696	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	43,969,559	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet G-1 | Date/Time Prepared: 7/27/2023 11:14 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		26,850,127		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,166,120				2.00
3.00	Total (sum of line 1 and line 2)		28,016,247		0		3.00
4.00	PRIOR PERIOD ADJUSTMENT	9,038,424		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)		9,038,424		0		10.00
11.00	Subtotal (line 3 plus line 10)		37,054,671		0		11.00
12.00	ROUNDING	2		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)		2		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		37,054,669		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	PRIOR PERIOD ADJUSTMENT		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	ROUNDING		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: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 7/27/2023 11:14 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	685,805		685,805	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	176,241		176,241	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)	862,046		862,046	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)	862,046		862,046	17.00
18.00	Ancillary services	974,771	34,487,244	35,462,015	18.00
19.00	Outpatient services	16,068	16,502,754	16,518,822	19.00
20.00	RURAL HEALTH CLINIC	0	2,437,093	2,437,093	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	CULBERTSON GARDENS	0	0	0	27.00
27.01	DIETARY	0	83,504	83,504	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,852,885	53,510,595	55,363,480	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,904,203		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	PATIENT COLLECT FEES-OTHER REV	58,208			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)		58,208		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		26,845,995		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1333	Period: From 03/01/2022 To 02/28/2023	Worksheet G-3 Date/Time Prepared: 7/27/2023 11:14 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	55,363,480	1.00
2.00	Less contractual allowances and discounts on patients' accounts	29,385,787	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,977,693	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,845,995	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-868,302	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	45,340	6.00
7.00	Income from investments	36,812	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	1,057,019	24.00
24.01	PROPERTY TAXES	746,451	24.01
24.02	NONCAPITAL GRANTS AND GIFTS	128,417	24.02
24.03	LOSS ON DISPOSAL OF ASSETS	-1,253	24.03
24.50	COVID-19 PHE Funding	21,636	24.50
25.00	Total other income (sum of lines 6-24)	2,034,422	25.00
26.00	Total (line 5 plus line 25)	1,166,120	26.00
27.00	INTEREST EXPENSE	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)	1,166,120	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1333 | Component CCN: 14-3483 | Period: From 03/01/2022 To 02/28/2023 | Worksheet M-1 | Date/Time Prepared: 7/27/2023 11:14 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	165,511	150,227	315,738	17,974	333,712	1.00
2.00	Physician Assistant	206,472	0	206,472	0	206,472	2.00
3.00	Nurse Practitioner	532,563	0	532,563	0	532,563	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	537,052	0	537,052	-34,824	502,228	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	31,079	0	31,079	0	31,079	7.00
8.00	Laboratory Technician	58,894	0	58,894	-24,071	34,823	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,531,571	150,227	1,681,798	-40,921	1,640,877	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	142,123	142,123	0	142,123	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	142,123	142,123	0	142,123	14.00
15.00	Medical Supplies	0	82,753	82,753	0	82,753	15.00
16.00	Transportation (Health Care Staff)	0	10,532	10,532	0	10,532	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	93,285	93,285	0	93,285	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,531,571	385,635	1,917,206	-40,921	1,876,285	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	1,997	0	1,997	0	1,997	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)	1,997	0	1,997	0	1,997	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	415,441	87,285	502,726	-49,179	453,547	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	415,441	87,285	502,726	-49,179	453,547	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,949,009	472,920	2,421,929	-90,100	2,331,829	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1333 | Period: From 03/01/2022 To 02/28/2023 | Worksheet M-1

Component CCN: 14-3483 | Date/Time Prepared: 7/27/2023 11:14 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	333,712		1.00
2.00	Physician Assistant	0	206,472		2.00
3.00	Nurse Practitioner	0	532,563		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	502,228		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	31,079		7.00
8.00	Laboratory Technician	0	34,823		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,640,877		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	142,123		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	142,123		14.00
15.00	Medical Supplies	0	82,753		15.00
16.00	Transportation (Health Care Staff)	0	10,532		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	93,285		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,876,285		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	1,997		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	1,997		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-14,929	438,618		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-14,929	438,618		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-14,929	2,316,900		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1333 | Component CCN: 14-3483 | Period: From 03/01/2022 To 02/28/2023 | Worksheet M-2 | Date/Time Prepared: 7/27/2023 11:14 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	0.43	1,818	4,200	1,806		1.00
2.00	Physician Assistant	0.79	803	2,100	1,659		2.00
3.00	Nurse Practitioner	3.93	9,755	2,100	8,253		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.15	12,376		11,718	12,376	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	0.47	324			324	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.62	12,700			12,700	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,876,285	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,997	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,878,282	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.998937	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					438,618	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,533,814	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,972,432	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,972,432	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,970,335	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,846,620	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1333 Component CCN: 14-3483	Period: From 03/01/2022 To 02/28/2023	Worksheet M-3 Date/Time Prepared: 7/27/2023 11:14 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,846,620	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			145,564	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			3,701,056	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			12,700	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)			12,700	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			291.42	7.00
		Calculation of Limit (1)			
		Rate Period 1 (03/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 02/28/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	205.48	213.29		8.00
9.00	Rate for Program covered visits (see instructions)	205.48	213.29		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	1,477	840		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	303,494	179,164		11.00
12.00	Program covered visits for mental health services (from contractor records)	67	36		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	13,767	7,678		13.00
14.00	Limit adjustment for mental health services (see instructions)	13,767	7,678		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	504,103		16.00
16.01	Total program charges (see instructions)(from contractor's records)		452,930		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,453		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,956		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.)		352,146		16.04
16.05	Total program cost (see instructions)	0	357,102		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		58,965		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		77,904		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		357,102		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		18,853		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		375,955		22.00
23.00	Allowable bad debts (see instructions)		23,445		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		15,239		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		23,349		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)		391,194		26.00
26.01	Sequestration adjustment (see instructions)		6,181		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		347,780		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)		37,233		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: 14-1333 | Component CCN: 14-3483 | Period: From 03/01/2022 To 02/28/2023 | Worksheet M-4 | Date/Time Prepared: 7/27/2023 11:14 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,640,877	1,640,877	1,640,877	1,640,877	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000676	0.001560	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,109	2,560	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	50,043	17,291	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	51,152	19,851	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,876,285	1,876,285	1,876,285	1,876,285	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,970,335	1,970,335	1,970,335	1,970,335	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.027262	0.010580	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	53,715	20,846	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	104,867	40,697	0	0	10.00
11.00	Total number of injections/infusions (from your records)	232	535	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	452.01	76.07	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	20	129	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)	9,040	9,813	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)		145,564	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		18,853	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1333 Component CCN: 14-3483	Period: From 03/01/2022 To 02/28/2023	Worksheet M-5 Date/Time Prepared: 7/27/2023 11:14 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		347,780	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		347,780	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		37,233	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		385,013	7.00

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