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: 14-1348	Period: From 01/14/2023 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/27/2024 3:13 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/27/2024 Time: 3:13 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RED BUD REGIONAL HOSPITAL (14-1348) for the cost reporting period beginning 01/14/2023 and ending 09/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Amber Lipe		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	Amber Lipe			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	572,358	-521,857	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	1,323,558	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-389,267		0	10.00
200.00	TOTAL	0	1,895,916	-911,124	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: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2024 3:13 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: ST. CLEMENT BLVD	PO Box:			1.00
2.00	City: RED BUD	State: IL	Zip Code: 62278-	County: RANDOLPH	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	RED BUD REGIONAL HOSPITAL	141348	99914	1	07/01/2005	N	O	P	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	RED BUD HOSPITAL	14Z348	99914		08/10/2005	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	OLDER ADULT HEALTH CENTER	148514	99914		05/26/2011	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/14/2023	09/30/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2024 3:13 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2024 3:13 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
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
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: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2024 3:13 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2024 3:13 pm

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2024 3:13 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2024 3:13 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	51,257	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	N	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0778	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: DEACONESS HEALTH SYSTEM	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 600 MARY STREET	PO Box:		142.00
143.00	City: EVANSVILLE	State: IN	Zip Code: 47710	143.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2024 3:13 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/27/2024 3:13 pm

		Y/N	Date	
		1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	Y	01/14/2023	1.00

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	02/01/2024	Y	02/01/2024	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/27/2024 3:13 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	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?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	AUSTIN	FISHER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3172757438	AFISHER@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1348	Period: From 01/14/2023 To 09/30/2023	Worksheet S-2 Part II Date/Time Prepared: 2/27/2024 3:13 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR 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: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2024 3:13 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	6,500	32,136.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	6,500	32,136.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	6,500	32,136.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2024 3:13 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	785	0	1,339			1.00
2.00	HMO and other (see instructions)	285	4				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	1,618	0	1,618			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	559			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,403	0	3,516			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)	2,403	0	3,516	0.00	64.77	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	3,705	1,065	9,576	0.00	14.83	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	79.60	27.00
28.00	Observation Bed Days		0	323			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: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2024 3:13 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	225	0	409	1.00
2.00	HMO and other (see instructions)			61	1		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	225	0	409	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1348 | Component CCN: 14-8514 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/27/2024 3:13 pm

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	325 SPRING STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	RED BUD	IL	62278	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	16:00	07:00	19:00	07:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		RANDOLPH				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	19:00	07:00	19:00	07:00	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1348
Component CCN: 14-8514

Period:
From 01/14/2023
To 09/30/2023

Worksheet S-8
Date/Time Prepared:
2/27/2024 3:13 pm

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	19:00	08:00	16:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 2/27/2024 3:13 pm

		1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA		
	Uncompensated and Indigent Care Cost-to-Charge Ratio		
1.00	Cost to charge ratio (see instructions)	0.219272	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,109,814	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,218,661	5.00
6.00	Medicaid charges	13,956,597	6.00
7.00	Medicaid cost (line 1 times line 6)	3,060,291	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	731,816	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	731,816	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	782,911	0	782,911	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	171,670	0	171,670	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	171,670	0	171,670	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	35,025	26.00
27.00	Medicare reimbursable bad debts (see instructions)	22,766	27.00
27.01	Medicare allowable bad debts (see instructions)	35,025	27.01
28.00	Non-Medicare bad debt amount (see instructions)	0	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	12,259	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	183,929	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	915,745	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 2/27/2024 3:13 pm

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

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

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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/27/2024 3:13 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,268,538	1,268,538	-139,404	1,129,134	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		427,095	427,095	1,803	428,898	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	130,126	39,618	169,744	572,789	742,533	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	494,475	10,464,320	10,958,795	-702,087	10,256,708	5.00
7.00	00700	OPERATION OF PLANT	215,353	863,566	1,078,919	-44,894	1,034,025	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	70,842	70,842	0	70,842	8.00
9.00	00900	HOUSEKEEPING	180,238	37,924	218,162	-7,103	211,059	9.00
10.00	01000	DIETARY	0	866,606	866,606	-508,838	357,768	10.00
11.00	01100	CAFETERIA	0	0	0	508,838	508,838	11.00
13.00	01300	NURSING ADMINISTRATION	257,374	52,091	309,465	-29,529	279,936	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	54,491	201,599	256,090	-90,942	165,148	14.00
15.00	01500	PHARMACY	248,223	952,042	1,200,265	-846,686	353,579	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,027	9,027	-984	8,043	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,818,167	279,189	2,097,356	3,400	2,100,756	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	297,017	202,431	499,448	4,396	503,844	50.00
53.00	05300	ANESTHESIOLOGY	0	252,504	252,504	-5,231	247,273	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	612,761	782,648	1,395,409	-2,680	1,392,729	54.00
60.00	06000	LABORATORY	583,920	529,730	1,113,650	-6,007	1,107,643	60.00
65.00	06500	RESPIRATORY THERAPY	240,716	59,658	300,374	-17,282	283,092	65.00
66.00	06600	PHYSICAL THERAPY	408,901	51,571	460,472	-1,199	459,273	66.00
67.00	06700	OCCUPATIONAL THERAPY	126,714	10,446	137,160	0	137,160	67.00
68.00	06800	SPEECH PATHOLOGY	34,163	4,249	38,412	0	38,412	68.00
69.00	06900	ELECTROCARDIOLOGY	3,290	243	3,533	19,263	22,796	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	88,978	88,978	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,600	11,600	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	845,257	845,257	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	357,681	357,681	0	357,681	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,223,750	347,611	1,571,361	117,074	1,688,435	88.00
91.00	09100	EMERGENCY	748,136	143,808	891,944	1,357	893,301	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)	7,677,815	18,275,037	25,952,852	-228,111	25,724,741	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	11,649	11,649	0	11,649	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	100,288	100,288	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	61,900	10,316	72,216	-5,312	66,904	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	133,135	133,135	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	7,739,715	18,297,002	26,036,717	0	26,036,717	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/27/2024 3:13 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-302,163	826,971		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	428,898		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	563,657	1,306,190		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,881,409	6,375,299		5.00
7.00	00700	OPERATION OF PLANT	188,694	1,222,719		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	70,842		8.00
9.00	00900	HOUSEKEEPING	115,932	326,991		9.00
10.00	01000	DIETARY	66,454	424,222		10.00
11.00	01100	CAFETERIA	-79,828	429,010		11.00
13.00	01300	NURSING ADMINISTRATION	183,644	463,580		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	165,148		14.00
15.00	01500	PHARMACY	185,251	538,830		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,573	12,616		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	108,226	2,208,982		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	503,844		50.00
53.00	05300	ANESTHESIOLOGY	-237,784	9,489		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,392,729		54.00
60.00	06000	LABORATORY	-12,822	1,094,821		60.00
65.00	06500	RESPIRATORY THERAPY	0	283,092		65.00
66.00	06600	PHYSICAL THERAPY	0	459,273		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	137,160		67.00
68.00	06800	SPEECH PATHOLOGY	0	38,412		68.00
69.00	06900	ELECTROCARDIOLOGY	0	22,796		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	88,978		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,600		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	845,257		73.00
76.00	03610	BLANK	0	0		76.00
76.01	03550	SLEEP LAB	0	0		76.01
76.02	03020	PSYCH SERVICES	0	357,681		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	542,993	2,231,428		88.00
91.00	09100	EMERGENCY	799,123	1,692,424		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)	-1,755,459	23,969,282		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	11,649		192.00
194.00	07950	HOME HEALTH	0	0		194.00
194.01	07951	MARKETING	0	100,288		194.01
194.02	07952	SENIOR CIRCLE	0	0		194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	66,904		194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0		194.04
194.05	07955	FREE STANDING NURSING HOME	0	133,135		194.05
194.06	07956	CLINIC CORPORATION	0	0		194.06
194.07	07957	VACANT SPACE	0	0		194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,755,459	24,281,258		200.00

RECLASSIFICATIONS | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/27/2024 3:13 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	596,509	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	116,383	2.00
	0		0	712,892	
	B - OXYGEN COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	11,561	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	11,561	
	D - OTHER CAPITAL COSTS				
1.00	ADMINISTRATIVE & GENERAL	5.00		137,601	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00		1,803	2.00
	0		0	139,404	
	E - MARKETING COSTS				
1.00	MARKETING	194.01	51,362	48,926	1.00
	0		51,362	48,926	
	F - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00		77,417	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		11,600	2.00
3.00	HOUSEKEEPING	9.00		2,643	3.00
4.00	ADULTS & PEDIATRICS	30.00		3,400	4.00
5.00	OPERATING ROOM	50.00		4,632	5.00
6.00	LABORATORY	60.00		8,576	6.00
7.00	RURAL HEALTH CLINIC	88.00		691	7.00
8.00	EMERGENCY	91.00		1,357	8.00
	0		0	110,316	
	G - RECLASS COST OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	845,257	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	845,257	
	H - CAFETERIA COSTS				
1.00	CAFETERIA	11.00	0	508,838	1.00
	0		0	508,838	
	I - ALLOCATE NUSRSING HOME COSTS				
1.00	FREE STANDING NURSING HOME	194.05	129,634	3,501	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	0		129,634	3,501	
	J - EKG RECLASS				
1.00	ELECTROCARDIOLOGY	69.00	19,263	0	1.00
2.00		0.00	0	0	2.00
	TOTALS		19,263	0	
500.00	Grand Total: Increases		200,259	2,380,695	500.00

RECLASSIFICATIONS | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/27/2024 3:13 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8,653	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	704,239	0		2.00
	0		0	712,892			
	B - OXYGEN COSTS						
1.00	OPERATING ROOM	50.00	0	236	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	10,693	0		2.00
3.00	RED BUD SPECIALTY CLINIC	194.03	0	632	0		3.00
	0		0	11,561			
	D - OTHER CAPITAL COSTS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00		139,404	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	139,404			
	E - MARKETING COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	51,362	48,926	0		1.00
	0		51,362	48,926			
	F - MEDICAL SUPPLIES						
1.00	OPERATION OF PLANT	7.00		1,262	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00		90,942	0		2.00
3.00	PHARMACY	15.00		3,731	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00		984	0		4.00
5.00	ANESTHESIOLOGY	53.00		3,818	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00		1,791	0		6.00
7.00	RESPIRATORY THERAPY	65.00		6,589	0		7.00
8.00	PHYSICAL THERAPY	66.00		1,199	0		8.00
	0		0	110,316			
	G - RECLASS COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00		842,955	0		1.00
2.00	ANESTHESIOLOGY	53.00		1,413	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00		889	0		3.00
	0		0	845,257			
	H - CAFETERIA COSTS						
1.00	DIETARY	10.00	0	508,838	0		1.00
	0		0	508,838			
	I - ALLOCATE NUSRSING HOME COSTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	15,067	0	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	33,452	1,709	0		2.00
3.00	OPERATION OF PLANT	7.00	41,840	1,792	0		3.00
4.00	HOUSEKEEPING	9.00	9,746	0	0		4.00
5.00	NURSING ADMINISTRATION	13.00	29,529	0	0		5.00
	0		129,634	3,501			
	J - EKG RECLASS						
1.00	LABORATORY	60.00	14,583	0	0		1.00
2.00	RED BUD SPECIALTY CLINIC	194.03	4,680	0	0		2.00
	TOTALS		19,263	0			
500.00	Grand Total: Decreases		200,259	2,380,695			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 2/27/2024 3:13 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	430,000	0	430,000	0	1.00
2.00	Land Improvements	311,428	0	0	0	311,428	2.00
3.00	Buildings and Fixtures	4,596,573	21,173,427	0	21,173,427	0	3.00
4.00	Building Improvements	5,098,421	0	0	0	5,098,421	4.00
5.00	Fixed Equipment	2,512,786	0	0	0	2,512,786	5.00
6.00	Movable Equipment	17,091,022	0	0	0	13,076,312	6.00
7.00	HIT designated Assets	3,709,787	0	0	0	3,709,787	7.00
8.00	Subtotal (sum of lines 1-7)	33,320,017	21,603,427	0	21,603,427	24,708,734	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	33,320,017	21,603,427	0	21,603,427	24,708,734	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	430,000	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	25,770,000	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	4,014,710	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	30,214,710	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	30,214,710	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 2/27/2024 3:13 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,268,538	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	427,095	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,695,633	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,268,538	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	427,095	2.00
3.00	Total (sum of lines 1-2)	0	1,695,633	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 2/27/2024 3:13 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	26,200,000	0	26,200,000	0.867127	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,014,710	0	4,014,710	0.132873	0	2.00
3.00	Total (sum of lines 1-2)	30,214,710	0	30,214,710	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,129,134	-302,163	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	428,898	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,558,032	-302,163	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	826,971	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	428,898	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,255,869	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/27/2024 3:13 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-302,163	CAP REL COSTS-BLDG & FIXT	1.00	10	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	0	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,610,212			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,746,256			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-79,828	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/27/2024 3:13 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PHYSICIAN ADVERTISING	A	-500	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-239	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	CRNA COSTS	A	-237,784	ANESTHESIOLOGY	53.00	0	33.02
33.03	ILLINIOS PROVIDER TAX	A	-1,218,661	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	CHARITABLE CONTRIBUTIONS	A	-350	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	HOSPITALIST SALARY	A	-48,400	ADULTS & PEDIATRICS	30.00	0	33.05
33.06	HOSPITALIST BENEFITS	A	-3,572	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,755,459				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/27/2024 3:13 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS	567,229	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	1,393,227	4,054,886	2.00
3.00	7.00	OPERATION OF PLANT	MAINTENANCE	188,694	0	3.00
3.01	9.00	HOUSEKEEPING	LAUNDRY	115,932	0	3.01
3.02	10.00	DIETARY	DIETARY	66,454	0	3.02
3.03	13.00	NURSING ADMINISTRATION	NURSING ADMIN	183,644	0	3.03
4.00	15.00	PHARMACY	PHARMACY	185,251	0	4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	4,579	0	4.01
4.02	30.00	ADULTS & PEDIATRICS	A&P	173,669	0	4.02
4.03	50.00	OPERATING ROOM	SURGERY	1,580,347	0	4.03
4.04	88.00	RURAL HEALTH CLINIC	RHC	542,993	0	4.04
4.05	91.00	EMERGENCY	ER	799,123	0	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,801,142	4,054,886	5.00

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

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

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

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

6.00	G		0.00	DEACONESS HOSP	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-1348	Period: From 01/14/2023 To 09/30/2023	Worksheet A-8-1 Date/Time Prepared: 2/27/2024 3:13 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	567,229	0		1.00
2.00	-2,661,659	0		2.00
3.00	188,694	0		3.00
3.01	115,932	0		3.01
3.02	66,454	0		3.02
3.03	183,644	0		3.03
4.00	185,251	0		4.00
4.01	4,579	0		4.01
4.02	173,669	0		4.02
4.03	1,580,347	0		4.03
4.04	542,993	0		4.04
4.05	799,123	0		4.05
5.00	1,746,256			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 2/27/2024 3:13 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	190,712	17,043	173,669	0	0	1.00
2.00	50.00	OPERATING ROOM	1,580,347	1,580,347	0	0	0	2.00
3.00	60.00	LABORATORY	44,791	12,822	31,969	0	0	3.00
4.00	76.02	PSYCH SERVICES	28,258	0	28,258	0	0	4.00
5.00	91.00	EMERGENCY	799,123	0	799,123	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,643,231	1,610,212	1,033,019		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	76.02	PSYCH SERVICES	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	17,043		1.00
2.00	50.00	OPERATING ROOM	0	0	0	1,580,347		2.00
3.00	60.00	LABORATORY	0	0	0	12,822		3.00
4.00	76.02	PSYCH SERVICES	0	0	0	0		4.00
5.00	91.00	EMERGENCY	0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,610,212		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/27/2024 3:13 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	826,971	826,971				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	428,898		428,898			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,306,190	15,302	8,181	1,329,673		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,375,299	123,798	66,184	71,441	6,636,722	5.00
7.00	00700	OPERATION OF PLANT	1,222,719	189,315	101,211	30,259	1,543,504	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	70,842	1,829	978	0	73,649	8.00
9.00	00900	HOUSEKEEPING	326,991	13,208	7,061	29,732	376,992	9.00
10.00	01000	DIETARY	424,222	35,297	18,870	0	478,389	10.00
11.00	01100	CAFETERIA	429,010	20,797	11,118	0	460,925	11.00
13.00	01300	NURSING ADMINISTRATION	463,580	9,623	5,144	39,734	518,081	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	165,148	7,515	4,018	9,503	186,184	14.00
15.00	01500	PHARMACY	538,830	9,981	5,336	43,288	597,435	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,616	21,042	11,249	0	44,907	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,208,982	85,148	45,521	317,073	2,656,724	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	503,844	44,781	23,940	51,797	624,362	50.00
53.00	05300	ANESTHESIOLOGY	9,489	1,014	542	0	11,045	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,392,729	32,878	17,577	106,860	1,550,044	54.00
60.00	06000	LABORATORY	1,094,821	19,100	10,211	99,287	1,223,419	60.00
65.00	06500	RESPIRATORY THERAPY	283,092	2,386	1,275	41,979	328,732	65.00
66.00	06600	PHYSICAL THERAPY	459,273	29,260	15,642	71,309	575,484	66.00
67.00	06700	OCCUPATIONAL THERAPY	137,160	3,287	1,757	22,098	164,302	67.00
68.00	06800	SPEECH PATHOLOGY	38,412	0	0	5,958	44,370	68.00
69.00	06900	ELECTROCARDIOLOGY	22,796	1,657	886	3,933	29,272	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	88,978	0	0	0	88,978	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,600	0	0	0	11,600	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	845,257	0	0	0	845,257	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	357,681	14,481	7,742	0	379,904	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,231,428	68,997	36,886	213,411	2,550,722	88.00
91.00	09100	EMERGENCY	1,692,424	20,015	10,700	130,468	1,853,607	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)	23,969,282	770,711	412,029	1,288,130	23,854,610	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	11,649	24,707	0	0	36,356	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	100,288	2,147	1,148	8,957	112,540	194.01
194.02	07952	SENIOR CIRCLE	0	4,295	2,296	0	6,591	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	66,904	25,111	13,425	9,979	115,419	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	133,135	0	0	22,607	155,742	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	24,281,258	826,971	428,898	1,329,673	24,281,258	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/27/2024 3:13 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,636,722					5.00
7.00	00700	OPERATION OF PLANT	586,956	2,130,460				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,007	8,224	109,880			8.00
9.00	00900	HOUSEKEEPING	143,361	59,386	25,802	605,541		9.00
10.00	01000	DIETARY	181,919	158,699	11,218	44,205	874,430	10.00
11.00	01100	CAFETERIA	175,278	93,503	0	26,045	0	11.00
13.00	01300	NURSING ADMINISTRATION	197,013	43,265	0	12,051	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	70,801	33,790	551	9,412	0	14.00
15.00	01500	PHARMACY	227,190	44,874	0	12,500	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,077	94,606	0	26,352	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,010,283	382,834	26,080	106,636	874,430	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	237,429	201,339	7,147	56,082	0	50.00
53.00	05300	ANESTHESIOLOGY	4,200	4,559	0	1,270	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	589,443	147,823	8,554	41,176	0	54.00
60.00	06000	LABORATORY	465,236	85,875	0	23,920	0	60.00
65.00	06500	RESPIRATORY THERAPY	125,009	10,727	0	2,988	0	65.00
66.00	06600	PHYSICAL THERAPY	218,842	131,554	8,834	36,644	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	62,480	14,779	0	4,117	0	67.00
68.00	06800	SPEECH PATHOLOGY	16,873	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,131	7,449	0	2,075	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	33,836	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,411	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	321,430	0	0	0	0	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	144,468	65,107	0	18,135	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	969,976	310,217	1,894	86,410	0	88.00
91.00	09100	EMERGENCY	704,880	89,987	19,135	25,066	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)	6,547,529	1,988,597	109,215	535,084	874,430	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	30,942	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	42,796	9,654	0	2,689	0	194.01
194.02	07952	SENIOR CIRCLE	2,506	19,308	0	5,378	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	43,891	112,901	665	31,448	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
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)	6,636,722	2,130,460	109,880	605,541	874,430	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/27/2024 3:13 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	755,751					11.00
13.00	01300	NURSING ADMINISTRATION	31,215	801,625				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,255	0	312,993			14.00
15.00	01500	PHARMACY	17,689	59,299	0	958,987		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	182,942	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	193,069	434,352	34,543	0	15,565	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,331	70,956	24,317	0	15,093	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,935	0	450	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,343	0	17,065	0	48,019	54.00
60.00	06000	LABORATORY	70,176	0	131,595	0	36,011	60.00
65.00	06500	RESPIRATORY THERAPY	25,666	57,506	6,722	0	5,261	65.00
66.00	06600	PHYSICAL THERAPY	49,597	0	1,443	0	11,273	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,411	0	147	0	3,254	67.00
68.00	06800	SPEECH PATHOLOGY	2,890	0	386	0	641	68.00
69.00	06900	ELECTROCARDIOLOGY	0	786	0	0	4,148	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	33,766	0	3,584	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	5,059	0	537	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	958,987	9,038	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	347	0	1,330	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	171,452	0	31,769	0	6,869	88.00
91.00	09100	EMERGENCY	73,876	178,726	22,207	0	21,869	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)	749,970	801,625	312,301	958,987	182,942	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	5,781	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	692	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
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)	755,751	801,625	312,993	958,987	182,942	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/27/2024 3:13 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,734,516	0	5,734,516		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,268,056	0	1,268,056		50.00
53.00	05300	ANESTHESIOLOGY	24,459	0	24,459		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,459,467	0	2,459,467		54.00
60.00	06000	LABORATORY	2,036,232	0	2,036,232		60.00
65.00	06500	RESPIRATORY THERAPY	562,611	0	562,611		65.00
66.00	06600	PHYSICAL THERAPY	1,033,671	0	1,033,671		66.00
67.00	06700	OCCUPATIONAL THERAPY	262,490	0	262,490		67.00
68.00	06800	SPEECH PATHOLOGY	65,160	0	65,160		68.00
69.00	06900	ELECTROCARDIOLOGY	54,861	0	54,861		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	160,164	0	160,164		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,607	0	21,607		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,134,712	0	2,134,712		73.00
76.00	03610	BLANK	0	0	0		76.00
76.01	03550	SLEEP LAB	0	0	0		76.01
76.02	03020	PSYCH SERVICES	609,291	0	609,291		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	4,129,309	0	4,129,309		88.00
91.00	09100	EMERGENCY	2,989,353	0	2,989,353		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)	23,545,959	0	23,545,959		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	67,298	0	67,298		192.00
194.00	07950	HOME HEALTH	0	0	0		194.00
194.01	07951	MARKETING	173,460	0	173,460		194.01
194.02	07952	SENIOR CIRCLE	33,783	0	33,783		194.02
194.03	07953	RED BUD SPECIALTY CLINIC	305,016	0	305,016		194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0		194.04
194.05	07955	FREE STANDING NURSING HOME	155,742	0	155,742		194.05
194.06	07956	CLINIC CORPORATION	0	0	0		194.06
194.07	07957	VACANT SPACE	0	0	0		194.07
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)	24,281,258	0	24,281,258		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/27/2024 3:13 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	15,302	8,181	23,483	23,483	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	123,798	66,184	189,982	1,262	5.00
7.00	00700	OPERATION OF PLANT	0	189,315	101,211	290,526	534	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,829	978	2,807	0	8.00
9.00	00900	HOUSEKEEPING	0	13,208	7,061	20,269	525	9.00
10.00	01000	DIETARY	0	35,297	18,870	54,167	0	10.00
11.00	01100	CAFETERIA	0	20,797	11,118	31,915	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	9,623	5,144	14,767	702	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,515	4,018	11,533	168	14.00
15.00	01500	PHARMACY	0	9,981	5,336	15,317	765	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,042	11,249	32,291	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	85,148	45,521	130,669	5,601	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	44,781	23,940	68,721	915	50.00
53.00	05300	ANESTHESIOLOGY	0	1,014	542	1,556	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,878	17,577	50,455	1,887	54.00
60.00	06000	LABORATORY	0	19,100	10,211	29,311	1,754	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,386	1,275	3,661	741	65.00
66.00	06600	PHYSICAL THERAPY	0	29,260	15,642	44,902	1,259	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,287	1,757	5,044	390	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	105	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,657	886	2,543	69	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
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	14,481	7,742	22,223	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	68,997	36,886	105,883	3,769	88.00
91.00	09100	EMERGENCY	0	20,015	10,700	30,715	2,304	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	770,711	412,029	1,182,740	22,750	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	24,707	0	24,707	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	2,147	1,148	3,295	158	194.01
194.02	07952	SENIOR CIRCLE	0	4,295	2,296	6,591	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	25,111	13,425	38,536	176	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	399	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	826,971	428,898	1,255,869	23,483	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/27/2024 3:13 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	191,244					5.00
7.00	00700	OPERATION OF PLANT	16,914	307,974				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	807	1,189	4,803			8.00
9.00	00900	HOUSEKEEPING	4,131	8,585	1,128	34,638		9.00
10.00	01000	DIETARY	5,242	22,941	490	2,529	85,369	10.00
11.00	01100	CAFETERIA	5,051	13,517	0	1,490	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,677	6,254	0	689	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,040	4,885	24	538	0	14.00
15.00	01500	PHARMACY	6,547	6,487	0	715	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	492	13,676	0	1,507	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,114	55,340	1,141	6,100	85,369	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,842	29,105	312	3,208	0	50.00
53.00	05300	ANESTHESIOLOGY	121	659	0	73	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,985	21,369	374	2,355	0	54.00
60.00	06000	LABORATORY	13,406	12,414	0	1,368	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,602	1,551	0	171	0	65.00
66.00	06600	PHYSICAL THERAPY	6,306	19,017	386	2,096	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,800	2,136	0	235	0	67.00
68.00	06800	SPEECH PATHOLOGY	486	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	321	1,077	0	119	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	975	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	127	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,262	0	0	0	0	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	4,163	9,412	0	1,037	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	27,951	44,844	83	4,943	0	88.00
91.00	09100	EMERGENCY	20,312	13,008	836	1,434	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)	188,674	287,466	4,774	30,607	85,369	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	1,770	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	1,233	1,396	0	154	0	194.01
194.02	07952	SENIOR CIRCLE	72	2,791	0	308	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	1,265	16,321	29	1,799	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
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)	191,244	307,974	4,803	34,638	85,369	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/27/2024 3:13 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	51,973					11.00
13.00	01300	NURSING ADMINISTRATION	2,147	30,236				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	843	0	20,031			14.00
15.00	01500	PHARMACY	1,216	2,237	0	33,284		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	47,966	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,277	16,383	2,211	0	4,079	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,155	2,676	1,556	0	3,955	50.00
53.00	05300	ANESTHESIOLOGY	0	0	188	0	118	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,943	0	1,092	0	12,608	54.00
60.00	06000	LABORATORY	4,826	0	8,423	0	9,437	60.00
65.00	06500	RESPIRATORY THERAPY	1,765	2,169	430	0	1,379	65.00
66.00	06600	PHYSICAL THERAPY	3,411	0	92	0	2,954	66.00
67.00	06700	OCCUPATIONAL THERAPY	922	0	9	0	853	67.00
68.00	06800	SPEECH PATHOLOGY	199	0	25	0	168	68.00
69.00	06900	ELECTROCARDIOLOGY	0	30	0	0	1,087	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,161	0	939	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	324	0	141	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	33,284	2,368	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	22	0	349	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	11,791	0	2,033	0	1,800	88.00
91.00	09100	EMERGENCY	5,080	6,741	1,421	0	5,731	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)	51,575	30,236	19,987	33,284	47,966	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	398	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	44	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
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)	51,973	30,236	20,031	33,284	47,966	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/27/2024 3:13 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	349,284	0	349,284		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	119,445	0	119,445		50.00
53.00	05300	ANESTHESIOLOGY	2,715	0	2,715		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	111,068	0	111,068		54.00
60.00	06000	LABORATORY	80,939	0	80,939		60.00
65.00	06500	RESPIRATORY THERAPY	15,469	0	15,469		65.00
66.00	06600	PHYSICAL THERAPY	80,423	0	80,423		66.00
67.00	06700	OCCUPATIONAL THERAPY	11,389	0	11,389		67.00
68.00	06800	SPEECH PATHOLOGY	983	0	983		68.00
69.00	06900	ELECTROCARDIOLOGY	5,246	0	5,246		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,075	0	4,075		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	592	0	592		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,914	0	44,914		73.00
76.00	03610	BLANK	0	0	0		76.00
76.01	03550	SLEEP LAB	0	0	0		76.01
76.02	03020	PSYCH SERVICES	37,206	0	37,206		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	203,097	0	203,097		88.00
91.00	09100	EMERGENCY	87,582	0	87,582		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)	1,154,427	0	1,154,427		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	26,477	0	26,477		192.00
194.00	07950	HOME HEALTH	0	0	0		194.00
194.01	07951	MARKETING	6,634	0	6,634		194.01
194.02	07952	SENIOR CIRCLE	9,762	0	9,762		194.02
194.03	07953	RED BUD SPECIALTY CLINIC	58,170	0	58,170		194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0		194.04
194.05	07955	FREE STANDING NURSING HOME	399	0	399		194.05
194.06	07956	CLINIC CORPORATION	0	0	0		194.06
194.07	07957	VACANT SPACE	0	0	0		194.07
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)	1,255,869	0	1,255,869		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/27/2024 3:13 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	124,782					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		121,054				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,309	2,309	7,624,656			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,680	18,680	409,661	-6,636,722	17,452,438	5.00
7.00	00700	OPERATION OF PLANT	28,566	28,566	173,513	0	1,543,504	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	276	276	0	0	73,649	8.00
9.00	00900	HOUSEKEEPING	1,993	1,993	170,492	0	376,992	9.00
10.00	01000	DIETARY	5,326	5,326	0	0	478,389	10.00
11.00	01100	CAFETERIA	3,138	3,138	0	0	460,925	11.00
13.00	01300	NURSING ADMINISTRATION	1,452	1,452	227,845	0	518,081	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,134	1,134	54,491	0	186,184	14.00
15.00	01500	PHARMACY	1,506	1,506	248,223	0	597,435	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,175	3,175	0	0	44,907	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,848	12,848	1,818,167	0	2,656,724	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,757	6,757	297,017	0	624,362	50.00
53.00	05300	ANESTHESIOLOGY	153	153	0	0	11,045	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,961	4,961	612,761	0	1,550,044	54.00
60.00	06000	LABORATORY	2,882	2,882	569,337	0	1,223,419	60.00
65.00	06500	RESPIRATORY THERAPY	360	360	240,716	0	328,732	65.00
66.00	06600	PHYSICAL THERAPY	4,415	4,415	408,901	0	575,484	66.00
67.00	06700	OCCUPATIONAL THERAPY	496	496	126,714	0	164,302	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	34,163	0	44,370	68.00
69.00	06900	ELECTROCARDIOLOGY	250	250	22,553	0	29,272	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	88,978	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	11,600	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	845,257	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	2,185	2,185	0	0	379,904	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,411	10,411	1,223,750	0	2,550,722	88.00
91.00	09100	EMERGENCY	3,020	3,020	748,136	0	1,853,607	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)	116,293	116,293	7,386,440	-6,636,722	17,217,888	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	3,728	0	0	-36,356	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	324	324	51,362	0	112,540	194.01
194.02	07952	SENIOR CIRCLE	648	648	0	0	6,591	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	3,789	3,789	57,220	0	115,419	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	129,634	-155,742	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
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)	826,971	428,898	1,329,673		6,636,722	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.627326	3.543030	0.174391		0.380275	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			23,483		191,244	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003080		0.010958	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: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/27/2024 3:13 pm

		Cost Center Description	OPERATION OF PLANT (SQ FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FULL TIME EQUIVALENT)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	71,499					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	276	130,481				8.00
9.00	00900	HOUSEKEEPING	1,993	30,639	72,958			9.00
10.00	01000	DIETARY	5,326	13,321	5,326	10,548		10.00
11.00	01100	CAFETERIA	3,138	0	3,138	0	6,537	11.00
13.00	01300	NURSING ADMINISTRATION	1,452	0	1,452	0	270	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,134	654	1,134	0	106	14.00
15.00	01500	PHARMACY	1,506	0	1,506	0	153	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,175	0	3,175	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,848	30,971	12,848	10,548	1,670	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,757	8,487	6,757	0	271	50.00
53.00	05300	ANESTHESIOLOGY	153	0	153	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,961	10,158	4,961	0	496	54.00
60.00	06000	LABORATORY	2,882	0	2,882	0	607	60.00
65.00	06500	RESPIRATORY THERAPY	360	0	360	0	222	65.00
66.00	06600	PHYSICAL THERAPY	4,415	10,490	4,415	0	429	66.00
67.00	06700	OCCUPATIONAL THERAPY	496	0	496	0	116	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	25	68.00
69.00	06900	ELECTROCARDIOLOGY	250	0	250	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
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	2,185	0	2,185	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,411	2,249	10,411	0	1,483	88.00
91.00	09100	EMERGENCY	3,020	22,722	3,020	0	639	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)	66,738	129,691	64,469	10,548	6,487	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	3,728	0	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	324	0	324	0	50	194.01
194.02	07952	SENIOR CIRCLE	648	0	648	0	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	3,789	790	3,789	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
194.07	07957	VACANT SPACE	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,130,460	109,880	605,541	874,430	755,751	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	29.797060	0.842115	8.299857	82.900076	115.611290	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	307,974	4,803	34,638	85,369	51,973	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.307389	0.036810	0.474766	8.093383	7.950589	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: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/27/2024 3:13 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING SALARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	3,355,549					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	717,609				14.00
15.00	01500	PHARMACY	248,223	0	845,257			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	106,291,763		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,818,167	79,197	0	9,044,437		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	297,017	55,752	0	8,769,945		50.00
53.00	05300	ANESTHESIOLOGY	0	6,729	0	261,459		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	39,125	0	27,893,341		54.00
60.00	06000	LABORATORY	0	301,714	0	20,924,380		60.00
65.00	06500	RESPIRATORY THERAPY	240,716	15,411	0	3,057,050		65.00
66.00	06600	PHYSICAL THERAPY	0	3,308	0	6,550,073		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	337	0	1,890,511		67.00
68.00	06800	SPEECH PATHOLOGY	0	885	0	372,329		68.00
69.00	06900	ELECTROCARDIOLOGY	3,290	0	0	2,410,441		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	77,417	0	2,082,724		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,600	0	312,074		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	845,257	5,251,325		73.00
76.00	03610	BLANK	0	0	0	0		76.00
76.01	03550	SLEEP LAB	0	0	0	0		76.01
76.02	03020	PSYCH SERVICES	0	795	0	773,050		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	72,838	0	3,991,414		88.00
91.00	09100	EMERGENCY	748,136	50,914	0	12,707,210		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)	3,355,549	716,022	845,257	106,291,763		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	HOME HEALTH	0	0	0	0		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0		194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	1,587	0	0		194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0		194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0		194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0		194.06
194.07	07957	VACANT SPACE	0	0	0	0		194.07
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)	801,625	312,993	958,987	182,942		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.238895	0.436161	1.134551	0.001721		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	30,236	20,031	33,284	47,966		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.009011	0.027914	0.039377	0.000451		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: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 3:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,734,516		5,734,516	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,268,056		1,268,056	0	0	50.00
53.00	05300	ANESTHESIOLOGY	24,459		24,459	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,459,467		2,459,467	0	0	54.00
60.00	06000	LABORATORY	2,036,232		2,036,232	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	562,611	0	562,611	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,033,671	0	1,033,671	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	262,490	0	262,490	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	65,160	0	65,160	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	54,861		54,861	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	160,164		160,164	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,607		21,607	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,134,712		2,134,712	0	0	73.00
76.00	03610	BLANK	0		0	0	0	76.00
76.01	03550	SLEEP LAB	0		0	0	0	76.01
76.02	03020	PSYCH SERVICES	609,291		609,291	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,129,309		4,129,309	0	0	88.00
91.00	09100	EMERGENCY	2,989,353		2,989,353	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	554,339		554,339		0	92.00
200.00		Subtotal (see instructions)	24,100,298	0	24,100,298	0	0	200.00
201.00		Less Observation Beds	554,339		554,339		0	201.00
202.00		Total (see instructions)	23,545,959	0	23,545,959	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 3:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,044,437		9,044,437			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	498,700	8,271,245	8,769,945	0.144591	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	17,382	244,077	261,459	0.093548	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,004,597	25,888,744	27,893,341	0.088174	0.000000	54.00
60.00	06000	LABORATORY	3,938,955	16,985,425	20,924,380	0.097314	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,188,203	868,847	3,057,050	0.184037	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,689,015	3,861,058	6,550,073	0.157811	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,697,943	192,568	1,890,511	0.138846	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	247,750	124,579	372,329	0.175007	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	141,053	2,269,388	2,410,441	0.022760	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,153,073	929,651	2,082,724	0.076901	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	312,074	312,074	0.069237	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,516,195	3,735,130	5,251,325	0.406509	0.000000	73.00
76.00	03610	BLANK	0	0	0	0.000000	0.000000	76.00
76.01	03550	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	773,050	773,050	0.788165	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,991,414	3,991,414			88.00
91.00	09100	EMERGENCY	539,062	12,168,148	12,707,210	0.235249	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	91,005	999,460	1,090,465	0.508351	0.000000	92.00
200.00		Subtotal (see instructions)	25,767,370	81,614,858	107,382,228			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	25,767,370	81,614,858	107,382,228			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 3:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03610	BLANK	0.000000		76.00
76.01	03550	SLEEP LAB	0.000000		76.01
76.02	03020	PSYCH SERVICES	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 3:13 pm

Title XIX | Hospital | PPS

		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	5,734,516		5,734,516	0	5,734,516	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,268,056		1,268,056	0	1,268,056	50.00
53.00	05300	ANESTHESIOLOGY	24,459		24,459	0	24,459	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,459,467		2,459,467	0	2,459,467	54.00
60.00	06000	LABORATORY	2,036,232		2,036,232	0	2,036,232	60.00
65.00	06500	RESPIRATORY THERAPY	562,611	0	562,611	0	562,611	65.00
66.00	06600	PHYSICAL THERAPY	1,033,671	0	1,033,671	0	1,033,671	66.00
67.00	06700	OCCUPATIONAL THERAPY	262,490	0	262,490	0	262,490	67.00
68.00	06800	SPEECH PATHOLOGY	65,160	0	65,160	0	65,160	68.00
69.00	06900	ELECTROCARDIOLOGY	54,861		54,861	0	54,861	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	160,164		160,164	0	160,164	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,607		21,607	0	21,607	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,134,712		2,134,712	0	2,134,712	73.00
76.00	03610	BLANK	0		0	0	0	76.00
76.01	03550	SLEEP LAB	0		0	0	0	76.01
76.02	03020	PSYCH SERVICES	609,291		609,291	0	609,291	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,129,309		4,129,309	0	4,129,309	88.00
91.00	09100	EMERGENCY	2,989,353		2,989,353	0	2,989,353	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	554,339		554,339		554,339	92.00
200.00		Subtotal (see instructions)	24,100,298	0	24,100,298	0	24,100,298	200.00
201.00		Less Observation Beds	554,339		554,339		554,339	201.00
202.00		Total (see instructions)	23,545,959	0	23,545,959	0	23,545,959	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 3:13 pm

Title XIX | Hospital | PPS

		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	9,044,437		9,044,437			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	498,700	8,271,245	8,769,945	0.144591	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	17,382	244,077	261,459	0.093548	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,004,597	25,888,744	27,893,341	0.088174	0.000000	54.00
60.00	06000	LABORATORY	3,938,955	16,985,425	20,924,380	0.097314	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,188,203	868,847	3,057,050	0.184037	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,689,015	3,861,058	6,550,073	0.157811	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,697,943	192,568	1,890,511	0.138846	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	247,750	124,579	372,329	0.175007	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	141,053	2,269,388	2,410,441	0.022760	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,153,073	929,651	2,082,724	0.076901	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	312,074	312,074	0.069237	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,516,195	3,735,130	5,251,325	0.406509	0.000000	73.00
76.00	03610	BLANK	0	0	0	0.000000	0.000000	76.00
76.01	03550	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	773,050	773,050	0.788165	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,991,414	3,991,414	1.034548	0.000000	88.00
91.00	09100	EMERGENCY	539,062	12,168,148	12,707,210	0.235249	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	91,005	999,460	1,090,465	0.508351	0.000000	92.00
200.00		Subtotal (see instructions)	25,767,370	81,614,858	107,382,228			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	25,767,370	81,614,858	107,382,228			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/27/2024 3:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.144591		50.00
53.00	05300	ANESTHESIOLOGY	0.093548		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.088174		54.00
60.00	06000	LABORATORY	0.097314		60.00
65.00	06500	RESPIRATORY THERAPY	0.184037		65.00
66.00	06600	PHYSICAL THERAPY	0.157811		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.138846		67.00
68.00	06800	SPEECH PATHOLOGY	0.175007		68.00
69.00	06900	ELECTROCARDIOLOGY	0.022760		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.076901		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.069237		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.406509		73.00
76.00	03610	BLANK	0.000000		76.00
76.01	03550	SLEEP LAB	0.000000		76.01
76.02	03020	PSYCH SERVICES	0.788165		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	1.034548		88.00
91.00	09100	EMERGENCY	0.235249		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.508351		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part II Date/Time Prepared: 2/27/2024 3:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,268,056	119,445	1,148,611	0	0	50.00
53.00	05300	ANESTHESIOLOGY	24,459	2,715	21,744	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,459,467	111,068	2,348,399	0	0	54.00
60.00	06000	LABORATORY	2,036,232	80,939	1,955,293	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	562,611	15,469	547,142	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,033,671	80,423	953,248	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	262,490	11,389	251,101	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	65,160	983	64,177	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	54,861	5,246	49,615	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	160,164	4,075	156,089	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,607	592	21,015	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,134,712	44,914	2,089,798	0	0	73.00
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	609,291	37,206	572,085	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,129,309	203,097	3,926,212	0	0	88.00
91.00	09100	EMERGENCY	2,989,353	87,582	2,901,771	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	554,339	33,764	520,575	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	18,365,782	838,907	17,526,875	0	0	200.00
201.00		Less Observation Beds	554,339	33,764	520,575	0	0	201.00
202.00		Total (line 200 minus line 201)	17,811,443	805,143	17,006,300	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet C Part II Date/Time Prepared: 2/27/2024 3:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,268,056	8,769,945	0.144591		50.00
53.00	05300	ANESTHESIOLOGY	24,459	261,459	0.093548		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,459,467	27,893,341	0.088174		54.00
60.00	06000	LABORATORY	2,036,232	20,924,380	0.097314		60.00
65.00	06500	RESPIRATORY THERAPY	562,611	3,057,050	0.184037		65.00
66.00	06600	PHYSICAL THERAPY	1,033,671	6,550,073	0.157811		66.00
67.00	06700	OCCUPATIONAL THERAPY	262,490	1,890,511	0.138846		67.00
68.00	06800	SPEECH PATHOLOGY	65,160	372,329	0.175007		68.00
69.00	06900	ELECTROCARDIOLOGY	54,861	2,410,441	0.022760		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	160,164	2,082,724	0.076901		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,607	312,074	0.069237		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,134,712	5,251,325	0.406509		73.00
76.00	03610	BLANK	0	0	0.000000		76.00
76.01	03550	SLEEP LAB	0	0	0.000000		76.01
76.02	03020	PSYCH SERVICES	609,291	773,050	0.788165		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	4,129,309	3,991,414	1.034548		88.00
91.00	09100	EMERGENCY	2,989,353	12,707,210	0.235249		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	554,339	1,090,465	0.508351		92.00
200.00		Subtotal (sum of lines 50 thru 199)	18,365,782	98,337,791			200.00
201.00		Less Observation Beds	554,339	0			201.00
202.00		Total (line 200 minus line 201)	17,811,443	98,337,791			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/27/2024 3:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	119,445	8,769,945	0.013620	192,285	2,619	50.00
53.00	05300	ANESTHESIOLOGY	2,715	261,459	0.010384	6,245	65	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	111,068	27,893,341	0.003982	677,779	2,699	54.00
60.00	06000	LABORATORY	80,939	20,924,380	0.003868	1,553,881	6,010	60.00
65.00	06500	RESPIRATORY THERAPY	15,469	3,057,050	0.005060	661,453	3,347	65.00
66.00	06600	PHYSICAL THERAPY	80,423	6,550,073	0.012278	430,005	5,280	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,389	1,890,511	0.006024	121,489	732	67.00
68.00	06800	SPEECH PATHOLOGY	983	372,329	0.002640	30,675	81	68.00
69.00	06900	ELECTROCARDIOLOGY	5,246	2,410,441	0.002176	41,784	91	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,075	2,082,724	0.001957	352,508	690	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	592	312,074	0.001897	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,914	5,251,325	0.008553	499,875	4,275	73.00
76.00	03610	BLANK	0	0	0.000000	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03020	PSYCH SERVICES	37,206	773,050	0.048129	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	203,097	3,991,414	0.050883	0	0	88.00
91.00	09100	EMERGENCY	87,582	12,707,210	0.006892	102,060	703	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	33,764	1,090,465	0.030963	2,805	87	92.00
200.00		Total (lines 50 through 199)	838,907	98,337,791		4,672,844	26,679	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/27/2024 3:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/27/2024 3:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	8,769,945	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	261,459	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	27,893,341	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	20,924,380	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,057,050	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,550,073	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,890,511	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	372,329	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,410,441	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,082,724	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	312,074	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,251,325	0.000000	73.00
76.00	03610	BLANK	0	0	0	0	0.000000	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	0	0	773,050	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,991,414	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	12,707,210	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,090,465	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	98,337,791		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/27/2024 3:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	192,285	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	6,245	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	677,779	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,553,881	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	661,453	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	430,005	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	121,489	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	30,675	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	41,784	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	352,508	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	499,875	0	0	0	73.00
76.00	03610	BLANK	0.000000	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	102,060	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,805	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,672,844	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/27/2024 3:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.144591	0	1,489,443	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.093548	0	42,674	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.088174	0	6,924,933	0	0	54.00
60.00	06000	LABORATORY	0.097314	0	5,212,919	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.184037	0	269,606	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.157811	0	1,209,160	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.138846	0	55,945	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.175007	0	36,385	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.022760	0	707,349	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.076901	0	146,702	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.069237	0	42,339	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.406509	0	2,168,567	75	0	73.00
76.00	03610	BLANK	0.000000	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0.788165	0	773,050	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	0.235249	0	2,556,504	45	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.508351	0	409,963	0	0	92.00
200.00		Subtotal (see instructions)		0	22,045,539	120	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	22,045,539	120	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/27/2024 3:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	215,360	0		50.00
53.00	05300	ANESTHESIOLOGY	3,992	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	610,599	0		54.00
60.00	06000	LABORATORY	507,290	0		60.00
65.00	06500	RESPIRATORY THERAPY	49,617	0		65.00
66.00	06600	PHYSICAL THERAPY	190,819	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	7,768	0		67.00
68.00	06800	SPEECH PATHOLOGY	6,368	0		68.00
69.00	06900	ELECTROCARDIOLOGY	16,099	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,282	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,931	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	881,542	30		73.00
76.00	03610	BLANK	0	0		76.00
76.01	03550	SLEEP LAB	0	0		76.01
76.02	03020	PSYCH SERVICES	609,291	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	601,415	11		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	208,405	0		92.00
200.00		Subtotal (see instructions)	3,922,778	41		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,922,778	41		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part I Date/Time Prepared: 2/27/2024 3:13 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	349,284	172,299	176,985	1,662	106.49	30.00
200.00	Total (lines 30 through 199)	349,284		176,985	1,662		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	0	0	30.00
200.00	Total (lines 30 through 199)	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/27/2024 3:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	119,445	8,769,945	0.013620	0	0	50.00
53.00	05300	ANESTHESIOLOGY	2,715	261,459	0.010384	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	111,068	27,893,341	0.003982	0	0	54.00
60.00	06000	LABORATORY	80,939	20,924,380	0.003868	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	15,469	3,057,050	0.005060	0	0	65.00
66.00	06600	PHYSICAL THERAPY	80,423	6,550,073	0.012278	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,389	1,890,511	0.006024	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	983	372,329	0.002640	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,246	2,410,441	0.002176	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,075	2,082,724	0.001957	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	592	312,074	0.001897	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,914	5,251,325	0.008553	0	0	73.00
76.00	03610	BLANK	0	0	0.000000	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03020	PSYCH SERVICES	37,206	773,050	0.048129	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	203,097	3,991,414	0.050883	0	0	88.00
91.00	09100	EMERGENCY	87,582	12,707,210	0.006892	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	33,764	1,090,465	0.030963	0	0	92.00
200.00		Total (lines 50 through 199)	838,907	98,337,791		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part III Date/Time Prepared: 2/27/2024 3:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,662	0.00	0	30.00
200.00		Total (lines 30 through 199)		0	1,662		0	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/27/2024 3:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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
76.00	03610	BLANK	0	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/27/2024 3:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	8,769,945	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	261,459	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	27,893,341	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	20,924,380	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,057,050	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,550,073	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,890,511	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	372,329	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,410,441	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,082,724	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	312,074	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,251,325	0.000000	73.00
76.00	03610	BLANK	0	0	0	0	0.000000	76.00
76.01	03550	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03020	PSYCH SERVICES	0	0	0	773,050	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,991,414	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	12,707,210	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,090,465	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	98,337,791		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/27/2024 3:13 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	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	0.000000	0	0	0	0	73.00
76.00	03610	BLANK	0.000000	0	0	0	0	76.00
76.01	03550	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03020	PSYCH SERVICES	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 3:13 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,839	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,662	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,339	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,618	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	559	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	785	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)	1,618	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	188.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	208.70	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,734,516	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)	105,338	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	2,882,166	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,852,350	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,852,350	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,716.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,347,225	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)	1,347,225	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 3:13 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	707,890	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)	2,055,115	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)	2,776,828	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	2,776,828	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)	323	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,716.22	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 3:13 pm

Title XVIII | Hospital | Cost

	Cost Center Description						
						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					554,339	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	349,284	5,734,516	0.060909	554,339	33,764	90.00
91.00	Nursing Program cost	0	5,734,516	0.000000	554,339	0	91.00
92.00	Allied health cost	0	5,734,516	0.000000	554,339	0	92.00
93.00	All other Medical Education	0	5,734,516	0.000000	554,339	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 3:13 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,839	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,662	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,339	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	1,618	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	559	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,734,516	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	2,828,798	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,905,718	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,905,718	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,748.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 3:13 pm

Title XIX | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	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)	0	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)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	323	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,748.33	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/27/2024 3:13 pm

Title XIX | Hospital | PPS

	Cost Center Description					1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					564,711	89.00
	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	349,284	5,734,516	0.060909	564,711	34,396	90.00
91.00	Nursing Program cost	0	5,734,516	0.000000	564,711	0	91.00
92.00	Allied health cost	0	5,734,516	0.000000	564,711	0	92.00
93.00	All other Medical Education	0	5,734,516	0.000000	564,711	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/27/2024 3:13 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,908,533		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.144591	192,285	27,803	50.00
53.00	05300	ANESTHESIOLOGY	0.093548	6,245	584	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.088174	677,779	59,762	54.00
60.00	06000	LABORATORY	0.097314	1,553,881	151,214	60.00
65.00	06500	RESPIRATORY THERAPY	0.184037	661,453	121,732	65.00
66.00	06600	PHYSICAL THERAPY	0.157811	430,005	67,860	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.138846	121,489	16,868	67.00
68.00	06800	SPEECH PATHOLOGY	0.175007	30,675	5,368	68.00
69.00	06900	ELECTROCARDIOLOGY	0.022760	41,784	951	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.076901	352,508	27,108	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.069237	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.406509	499,875	203,204	73.00
76.00	03610	BLANK	0.000000	0	0	76.00
76.01	03550	SLEEP LAB	0.000000	0	0	76.01
76.02	03020	PSYCH SERVICES	0.788165	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.235249	102,060	24,010	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.508351	2,805	1,426	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,672,844	707,890	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)		4,672,844		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet D-3

Component CCN: 14-Z348 | Date/Time Prepared: 2/27/2024 3:13 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.144591	5,001	723	50.00
53.00	05300	ANESTHESIOLOGY	0.093548	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.088174	159,718	14,083	54.00
60.00	06000	LABORATORY	0.097314	640,500	62,330	60.00
65.00	06500	RESPIRATORY THERAPY	0.184037	729,210	134,202	65.00
66.00	06600	PHYSICAL THERAPY	0.157811	1,561,239	246,381	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.138846	1,102,660	153,100	67.00
68.00	06800	SPEECH PATHOLOGY	0.175007	143,541	25,121	68.00
69.00	06900	ELECTROCARDIOLOGY	0.022760	12,095	275	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.076901	401,912	30,907	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.069237	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.406509	406,479	165,237	73.00
76.00	03610	BLANK	0.000000	0	0	76.00
76.01	03550	SLEEP LAB	0.000000	0	0	76.01
76.02	03020	PSYCH SERVICES	0.788165	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.235249	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.508351	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,162,355	832,359	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		5,162,355		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E Part B Date/Time Prepared: 2/27/2024 3:13 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,922,819	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,922,819	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	3,962,047	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)	4,041	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,311,618	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)	646,388	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)	646,388	30.00
31.00	Primary payer payments	271	31.00
32.00	Subtotal (line 30 minus line 31)	646,117	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)	35,025	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	22,766	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	35,025	36.00
37.00	Subtotal (see instructions)	668,883	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)	668,883	40.00
40.01	Sequestration adjustment (see instructions)	13,378	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	1,177,362	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-521,857	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: 14-1348	Period: From 01/14/2023 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/27/2024 3:13 pm
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E-1 Part I Date/Time Prepared: 2/27/2024 3:13 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,099,747		1,071,262	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	09/29/2023	129,200	09/29/2023	106,100	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)		129,200		106,100	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,228,947		1,177,362	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		572,358		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		521,857	6.02
7.00	Total Medicare program liability (see instructions)		1,801,305		655,505	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: 14-1348 | Component CCN: 14-Z348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/27/2024 3:13 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,155,715		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)		2,155,715		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		1,323,558		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,479,273		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: 14-1348	Period: From 01/14/2023 To 09/30/2023	Worksheet E-1 Part II Date/Time Prepared: 2/27/2024 3:13 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1348 | Component CCN: 14-Z348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet E-2 | Date/Time Prepared: 2/27/2024 3:13 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	2,804,596	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)	840,683	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	1,618	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)	3,645,279	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	3,645,279	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)	3,645,279	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	95,000	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	3,550,279	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)	3,550,279	0	19.00
19.01	Sequestration adjustment (see instructions)	71,006	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	2,155,715	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	1,323,558	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1348	Period: From 01/14/2023 To 09/30/2023	Worksheet E-3 Part V Date/Time Prepared: 2/27/2024 3:13 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,055,115	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)	2,055,115	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,075,666	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)	2,075,666	19.00
20.00	Deductibles (exclude professional component)	233,600	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,842,066	22.00
23.00	Coinsurance	4,000	23.00
24.00	Subtotal (line 22 minus line 23)	1,838,066	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	0	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,838,066	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,838,066	30.00
30.01	Sequestration adjustment (see instructions)	36,761	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,228,947	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	572,358	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet G | Date/Time Prepared: 2/27/2024 3:13 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3,367,836	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	13,457,646	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,791,884	0	0	0	6.00
7.00	Inventory	700,361	0	0	0	7.00
8.00	Prepaid expenses	242,645	0	0	0	8.00
9.00	Other current assets	193,807	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)	15,170,411	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	430,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	25,770,000	0	0	0	15.00
16.00	Accumulated depreciation	-966,375	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	4,014,710	0	0	0	23.00
24.00	Accumulated depreciation	-459,865	0	0	0	24.00
25.00	Minor equipment depreciable	6,097	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)	28,794,567	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	93,988	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	93,988	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	44,058,966	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,752,413	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,264,981	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	-337,264	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	12,948,511	0	0	0	43.00
44.00	Other current liabilities	4,900	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,633,541	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15,633,541	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	28,425,425				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)	28,425,425	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	44,058,966	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet G-1 | Date/Time Prepared: 2/27/2024 3:13 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		27,407,201		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,018,229				2.00
3.00	Total (sum of line 1 and line 2)		28,425,430		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		28,425,430		0		11.00
12.00	ROUNDING	5		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)		5		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		28,425,425		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	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: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/27/2024 3:13 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,293,687		5,293,687	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	2,945,243		2,945,243	5.00
6.00	Swing bed - NF	1,017,547		1,017,547	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	9,256,477		9,256,477	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	9,256,477		9,256,477	17.00
18.00	Ancillary services	15,800,965	64,538,382	80,339,347	18.00
19.00	Outpatient services	630,067	13,164,923	13,794,990	19.00
20.00	RURAL HEALTH CLINIC	0	3,991,414	3,991,414	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	PROFESSIONAL FEES	209,355	0	209,355	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	25,896,864	81,694,719	107,591,583	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,036,717		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		26,036,717		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1348 | Period: From 01/14/2023 To 09/30/2023 | Worksheet G-3 | Date/Time Prepared: 2/27/2024 3:13 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	107,591,583	1.00
2.00	Less contractual allowances and discounts on patients' accounts	84,800,034	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,791,549	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,036,717	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,245,168	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	14,938	6.00
7.00	Income from investments	4,157,713	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	79,828	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	6	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 OPERATING INCOME	10,912	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	4,263,397	25.00
26.00	Total (line 5 plus line 25)	1,018,229	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,018,229	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1348
Component CCN: 14-8514
Period: From 01/14/2023 To 09/30/2023
Worksheet M-1
Date/Time Prepared: 2/27/2024 3:13 pm

RHC I
Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	1,223,750	0	1,223,750	-634,746	589,004	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,223,750	0	1,223,750	-634,746	589,004	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	159,546	159,546	691	160,237	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	159,546	159,546	691	160,237	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,223,750	159,546	1,383,296	-634,055	749,241	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	35,402	35,402	0	35,402	29.00
30.00	Administrative Costs	0	152,663	152,663	751,129	903,792	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	188,065	188,065	751,129	939,194	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,223,750	347,611	1,571,361	117,074	1,688,435	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1348 | Component CCN: 14-8514 | Period: From 01/14/2023 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/27/2024 3:13 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	392,407	392,407		1.00
2.00	Physician Assistant	150,586	150,586		2.00
3.00	Nurse Practitioner	0	589,004		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	542,993	1,131,997		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	160,237		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	160,237		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	542,993	1,292,234		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	35,402		29.00
30.00	Administrative Costs	0	903,792		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	939,194		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	542,993	2,231,428		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1348 Component CCN: 14-8514

Period: From 01/14/2023 To 09/30/2023

Worksheet M-2

Date/Time Prepared: 2/27/2024 3:13 pm

RHC I

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.60	2,376	4,200	6,720		1.00
2.00	Physician Assistant	1.09	1,978	2,100	2,289		2.00
3.00	Nurse Practitioner	3.42	5,222	2,100	7,182		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.11	9,576		16,191	16,191	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	6.11	9,576			16,191	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)					1,292,234	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,292,234	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					939,194	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,897,881	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,837,075	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,837,075	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,837,075	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,129,309	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1348 Component CCN: 14-8514	Period: From 01/14/2023 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/27/2024 3:13 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		4,129,309	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		59,903	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		4,069,406	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		16,191	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)		16,191	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		251.34	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/14/2023 through 09/30/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	386.95	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	251.34	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	3,703	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	930,712	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	2	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	503	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	503	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	931,215	16.00
16.01	Total program charges (see instructions)(from contractor's records)		823,320	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		39,938	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		45,171	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.)		678,041	16.04
16.05	Total program cost (see instructions)	0	723,212	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		38,493	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		148,978	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		723,212	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		7,955	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		731,167	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		731,167	26.00
26.01	Sequestration adjustment (see instructions)		14,623	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		1,105,811	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)		-389,267	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: 14-1348 | Component CCN: 14-8514 | Period: From 01/14/2023 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/27/2024 3:13 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,131,997	1,131,997	1,131,997	1,131,997	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002882	0.001382	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	3,262	1,564	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	13,012	908	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	16,274	2,472	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,292,234	1,292,234	1,292,234	1,292,234	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,837,075	2,837,075	2,837,075	2,837,075	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.012594	0.001913	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	35,730	5,427	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	52,004	7,899	0	0	10.00
11.00	Total number of injections/infusions (from your records)	123	59	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	422.80	133.88	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	9	31	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)	3,805	4,150	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)		59,903	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)		7,955	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1348 Component CCN: 14-8514	Period: From 01/14/2023 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/27/2024 3:13 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,105,811	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)		1,105,811	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		389,267	6.02
7.00	Total Medicare program liability (see instructions)		716,544	7.00

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