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: 14-1353	Period: From 07/17/2023 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/26/2024 1:42 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/26/2024 Time: 1:42 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 IROQUOIS MEMORIAL HOSPITAL (14-1353) for the cost reporting period beginning 07/17/2023 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	Shawn Bransky		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	Shawn Bransky			2
3	Signatory Title	COO/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	-97,313	169,263	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	-21,126	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		-11,326		0	10.00
10.01	RURAL HEALTH CLINIC II	0		3,546		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-10,307		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		15,088		0	10.03
200.00	TOTAL	0	-118,439	166,264	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2024 1:42 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 200 FAIRMAN AVENUE	PO Box:			1.00
2.00	City: WATSEKA	State: IL	Zip Code: 60970	County:	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	IROQUOIS MEMORIAL HOSPITAL	141353	99914	1	07/17/2023	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	IROQUOIS MEMORIAL HOSPITAL	14Z353	99914		07/17/2023	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	IROQUOIS RESIDENT HOME	146049	99914		08/18/2003	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	IROQUOIS HOME HEALTH	147586	99914		09/30/1994	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	IROQUOIS MEMORIAL HOSPICE	141616	99914		11/04/2004				14.00
15.00	Hospital-Based Health Clinic - RHC	GILMAN CLINIC	143424	99914		09/04/1996	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	MILFORD CLINIC	143425	99914		10/09/1996	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	KENTLAND CLINIC	153979	99915		10/29/1996	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	MPS CLINIC	148551	99914		02/05/2016	N	O	N	15.03
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/17/2023	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2024 1:42 pm

		1.00	2.00	3.00	
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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2024 1:42 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2024 1:42 pm

					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

			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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2024 1:42 pm

		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
						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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2024 1:42 pm

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

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				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N		111.00
		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	111,033	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.		Y		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.		Y		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

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		1.00	2.00	
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

		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	Y	Y	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

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		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: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2024 1:42 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/29/2024	Y	01/29/2024	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: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet S-2 Part II Date/Time Prepared: 2/26/2024 1:42 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.	N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID	GOODMAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	608.270.2962	DGOODMAN@WIPFLI.COM	43.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 2/26/2024 1:42 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	1,900	4,449.00	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					14	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	1,900	4,449.00	14	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	1,900	4,449.00	14	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	44.00	35	2,660		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	1	76			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		61				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						34.00

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	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)	69	0	174			1.00
2.00	HMO and other (see instructions)	19	15				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	0	0	22			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	30			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	69	0	226			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)	69	0	226	0.00	150.90	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	47	0	2,004	0.00	26.20	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	509	0	1,502	0.00	7.40	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	9.40	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	201	0	848	0.00	4.80	26.00
26.01	RURAL HEALTH CLINIC II	155	0	794	0.00	3.10	26.01
26.02	RURAL HEALTH CLINIC III	354	0	1,351	0.00	8.30	26.02
26.03	RURAL HEALTH CLINIC IV	425	0	1,843	0.00	16.10	26.03
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	226.20	27.00
28.00	Observation Bed Days		0	141			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						34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2024 1:42 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	22	0	65	1.00
2.00	HMO and other (see instructions)			11	7		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	22	0	65	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	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
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

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 14-1353
Component CCN: 14-7586
Period: From 07/17/2023 To 09/30/2023
Worksheet S-4
Date/Time Prepared: 2/26/2024 1:42 pm
Home Health Agency I
PPS

					1.00		
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	230	0	60	290	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	26.00	0.00	9.00	35.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel			1.62	0.00	1.62	5.00
6.00	Direct Nursing Service			3.16	0.00	3.16	6.00
7.00	Nursing Supervisor			1.00	0.00	1.00	7.00
8.00	Physical Therapy Service			0.72	0.00	0.72	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.15	0.00	0.15	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.02	0.00	0.02	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.30	0.00	0.30	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
						CBSA Data	
						1.00	
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					3	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).					19180	20.00
20.01						99914	20.01
20.02						16580	20.02
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	210	65	2	0	277	21.00
22.00	Skilled Nursing Visit Charges	37,382	11,571	356	0	49,309	22.00
23.00	Physical Therapy Visits	65	36	0	0	101	23.00
24.00	Physical Therapy Visit Charges	11,571	6,408	0	0	17,979	24.00
25.00	Occupational Therapy Visits	13	8	0	0	21	25.00
26.00	Occupational Therapy Visit Charges	2,314	1,424	0	0	3,738	26.00
27.00	Speech Pathology Visits	0	0	0	0	0	27.00
28.00	Speech Pathology Visit Charges	0	0	0	0	0	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	70	54	0	0	124	31.00
32.00	Home Health Aide Visit Charges	7,650	5,967	0	0	13,617	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	358	163	2	0	523	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	58,917	25,370	356	0	84,643	35.00
36.00	Total Number of Episodes (standard/non outlier)	33		2	0	35	36.00
37.00	Total Number of Outlier Episodes		7		0	7	37.00
38.00	Total Non-Routine Medical Supply Charges	2,779	227	0	0	3,006	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1353 | Component CCN: 14-3424 | Period: From 07/17/2023 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/26/2024 1:42 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			508 E CRESENT		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	GILMAN		IL	60938	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:30	18:30	07:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		IROQUOIS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	07:00	17:00	08:30	18:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1353 Component CCN: 14-3424	Period: From 07/17/2023 To 09/30/2023	Worksheet S-8 Date/Time Prepared: 2/26/2024 1:42 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	08:30	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1353 | Component CCN: 14-3425 | Period: From 07/17/2023 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/26/2024 1:42 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			207 N AXTEL		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MILFORD		IL	60983	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:30	17:00	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		IROQUOIS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:30	18:30	08:30	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1353
Component CCN: 14-3425

Period:
From 07/17/2023
To 09/30/2023

Worksheet S-8

Date/Time Prepared:
2/26/2024 1:42 pm

RHC II

Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1353 | Component CCN: 15-3979 | Period: From 07/17/2023 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/26/2024 1:42 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			303 N SEVENTH		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	KENTLAND		IN	47951	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	17:00	08:30	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN	
			1.00		2.00	
14.00	RHC/FQHC name, CCN					14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		NEWTON				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	18:30	07:00	17:00	08:30	18:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1353
Component CCN: 15-3979

Period:
From 07/17/2023
To 09/30/2023

Worksheet S-8

Date/Time Prepared:
2/26/2024 1:42 pm

RHC III | 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	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1353 | Component CCN: 14-8551 | Period: From 07/17/2023 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/26/2024 1:42 pm

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			200 FAIRMAN AVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WATSEKA		IL	60970	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	17:00	08:30	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		IROQUOIS				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	18:30	07:00	17:00	08:30	18:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1353
Component CCN: 14-8551

Period:
From 07/17/2023
To 09/30/2023

Worksheet S-8

Date/Time Prepared:
2/26/2024 1:42 pm

RHC IV

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	17:00				11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 2/26/2024 1:42 pm

Hospice CCN: 14-1616 | Hospice I

		Unduplicated Days Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	2,875	0	76	2,951	11.00
12.00	Hospice Inpatient Respite Care	16	0	0	16	12.00
13.00	Hospice General Inpatient Care	7	0	2	9	13.00
14.00	Total Hospice Days	2,898	0	78	2,976	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 2/26/2024 1:42 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)	0.487797	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,104,301	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	3,049,032	6.00
7.00	Medicaid cost (line 1 times line 6)	1,487,309	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	383,008	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)	383,008	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)	16,177	0	16,177	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	7,891	0	7,891	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)	7,891	0	7,891	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)	1	26.00
27.00	Medicare reimbursable bad debts (see instructions)	0	27.00
27.01	Medicare allowable bad debts (see instructions)	0	27.01
28.00	Non-Medicare bad debt amount (see instructions)	1	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	0	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	7,891	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	390,899	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 2/26/2024 1:42 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: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/26/2024 1:42 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		307,649	307,649	-97,150	210,499	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	152,428	152,428	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	34,773	1,069,609	1,104,382	-243	1,104,139	4.00
5.01	00570	ADMITTING	56,886	2,092	58,978	0	58,978	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	15,529	-144	15,385	-84	15,301	5.02
5.03	00550	DATA PROCESSING	47,295	78,233	125,528	-188	125,340	5.03
5.04	01160	COMMUNICATIONS	0	20,997	20,997	11,055	32,052	5.04
5.05	00590	BUSINESS OFFICE	55,898	44,460	100,358	-203	100,155	5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	191,681	-304,029	-112,348	35	-112,313	5.06
7.00	00700	OPERATION OF PLANT	78,004	258,387	336,391	-624	335,767	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,218	328	15,546	0	15,546	8.00
9.00	00900	HOUSEKEEPING	70,510	1,833	72,343	0	72,343	9.00
10.00	01000	DIETARY	62,660	128,129	190,789	-119,102	71,687	10.00
11.00	01100	CAFETERIA	0	0	0	119,102	119,102	11.00
13.00	01300	NURSING ADMINISTRATION	33,510	12	33,522	0	33,522	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-62,771	-62,771	64,097	1,326	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	34,574	4,011	38,585	-218	38,367	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	163,125	512,779	675,904	-1,540	674,364	30.00
44.00	04400	SKILLED NURSING FACILITY	309,853	64,022	373,875	0	373,875	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	109,765	90,641	200,406	-14,544	185,862	50.00
53.00	05300	ANESTHESIOLOGY	0	54,369	54,369	-107	54,262	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	147,051	144,078	291,129	1,325	292,454	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	166,893	81,139	248,032	36,565	284,597	60.00
65.00	06500	RESPIRATORY THERAPY	94,933	25,346	120,279	-12,874	107,405	65.00
66.00	06600	PHYSICAL THERAPY	156,701	151,653	308,354	0	308,354	66.00
69.00	06900	ELECTROCARDIOLOGY	0	936	936	0	936	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	-83,295	-83,295	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	13,686	13,686	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	110,171	384,666	494,837	1,116	495,953	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	85,466	7,320	92,786	-13,010	79,776	88.00
88.01	08801	RURAL HEALTH CLINIC II	67,051	14,759	81,810	9,510	91,320	88.01
88.02	08802	RURAL HEALTH CLINIC III	187,026	13,834	200,860	15,014	215,874	88.02
88.03	08803	RURAL HEALTH CLINIC IV	403,499	21,949	425,448	-16,596	408,852	88.03
90.00	09000	CLINIC	33,092	76,699	109,791	-391	109,400	90.00
90.01	09001	ST ANNE CLINIC	45,678	27,300	72,978	-3,851	69,127	90.01
91.00	09100	EMERGENCY	265,617	567,307	832,924	-3,481	829,443	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	105,961	7,877	113,838	-579	113,259	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		55,278	55,278	-55,278	0	113.00
116.00	11600	HOSPICE	98,179	143,273	241,452	-575	240,877	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,246,599	3,994,021	7,240,620	0	7,240,620	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	9,298	7,586	16,884	0	16,884	194.01
194.02	07952	REFERENCE LAB	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	3,255,897	4,001,607	7,257,504	0	7,257,504	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/26/2024 1:42 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	0	210,499		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	152,428		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-490	1,103,649		4.00
5.01	00570	ADMITTING	0	58,978		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-589	14,712		5.02
5.03	00550	DATA PROCESSING	0	125,340		5.03
5.04	01160	COMMUNICATIONS	-2,233	29,819		5.04
5.05	00590	BUSINESS OFFICE	-264	99,891		5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	317,439	205,126		5.06
7.00	00700	OPERATION OF PLANT	-2,065	333,702		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,546		8.00
9.00	00900	HOUSEKEEPING	0	72,343		9.00
10.00	01000	DIETARY	-3,245	68,442		10.00
11.00	01100	CAFETERIA	-32,967	86,135		11.00
13.00	01300	NURSING ADMINISTRATION	27	33,549		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,326		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-37	38,330		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-167,832	506,532		30.00
44.00	04400	SKILLED NURSING FACILITY	-13,601	360,274		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	185,862		50.00
53.00	05300	ANESTHESIOLOGY	-47,682	6,580		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-8,811	283,643		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	-1,792	282,805		60.00
65.00	06500	RESPIRATORY THERAPY	0	107,405		65.00
66.00	06600	PHYSICAL THERAPY	256	308,610		66.00
69.00	06900	ELECTROCARDIOLOGY	0	936		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	82,396	-899		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,686		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10	495,963		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-3,378	76,398		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	91,320		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	215,874		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	408,852		88.03
90.00	09000	CLINIC	-79,195	30,205		90.00
90.01	09001	ST ANNE CLINIC	-55,569	13,558		90.01
91.00	09100	EMERGENCY	-121,173	708,270		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	113,259		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	-176	240,701		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-140,971	7,099,649		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	16,884		194.01
194.02	07952	REFERENCE LAB	0	0		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-140,971	7,116,533		200.00

RECLASSIFICATIONS | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/26/2024 1:42 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	64,097		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,288		2.00
3.00	LABORATORY	60.00	0	36,668		3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0	1		4.00
5.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	13,686		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
	TOTALS		0	115,740		
	B - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,115		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	17		2.00
3.00	OTHER ADMINISTRATIVE & GENERAL	5.06	0	184		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	108		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	TOTALS		0	1,424		
	C - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	129,212		1.00
	TOTALS		0	129,212		
	D - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	32,062		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	23,216		2.00
	TOTALS		0	55,278		
	E - TELEPHONE					
1.00	COMMUNICATIONS	5.04	0	11,055		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
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
	TOTALS		0	11,055		
	G - CAFETERIA					
1.00	CAFETERIA	11.00	38,611	80,491		1.00
	TOTALS		38,611	80,491		
	H - RHC SALARIES					
1.00	RURAL HEALTH CLINIC II	88.01	11,582	0		1.00
2.00	RURAL HEALTH CLINIC III	88.02	16,596	0		2.00
	TOTALS		28,178	0		
500.00	Grand Total: Increases		66,789	393,200		500.00

RECLASSIFICATIONS | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/26/2024 1:42 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - MEDICAL SUPPLIES						
1.00		0.00	0	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1,540	0		2.00
3.00	OPERATING ROOM	50.00	0	14,503	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	107	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	12,874	0		5.00
6.00	CLINIC	90.00	0	125	0		6.00
7.00	EMERGENCY	91.00	0	3,296	0		7.00
8.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	83,295	0		8.00
	TOTALS		0	115,740			
	B - DRUGS						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	OPERATING ROOM	50.00	0	41	0		3.00
4.00	LABORATORY	60.00	0	103	0		4.00
5.00	CLINIC	90.00	0	266	0		5.00
6.00	ST ANNE CLINIC	90.01	0	829	0		6.00
7.00	EMERGENCY	91.00	0	185	0		7.00
	TOTALS		0	1,424			
	C - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	129,212	9		1.00
	TOTALS		0	129,212			
	D - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	55,278	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	55,278			
	E - TELEPHONE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	260	0		1.00
2.00	PURCHASING RECEIVING AND STORES	5.02	0	84	0		2.00
3.00	DATA PROCESSING	5.03	0	188	0		3.00
4.00	BUSINESS OFFICE	5.05	0	203	0		4.00
5.00	OTHER ADMINISTRATIVE & GENERAL	5.06	0	149	0		5.00
6.00	OPERATION OF PLANT	7.00	0	624	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	218	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	71	0		8.00
9.00	HOME HEALTH AGENCY	101.00	0	579	0		9.00
10.00	HOSPICE	116.00	0	575	0		10.00
11.00	RURAL HEALTH CLINIC	88.00	0	1,428	0		11.00
12.00	RURAL HEALTH CLINIC III	88.02	0	1,582	0		12.00
13.00	RURAL HEALTH CLINIC II	88.01	0	2,072	0		13.00
14.00	ST ANNE CLINIC	90.01	0	3,022	0		14.00
	TOTALS		0	11,055			
	G - CAFETERIA						
1.00	DIETARY	10.00	38,611	80,491	0		1.00
	TOTALS		38,611	80,491			
	H - RHC SALARIES						
1.00	RURAL HEALTH CLINIC	88.00	11,582	0	0		1.00
2.00	RURAL HEALTH CLINIC IV	88.03	16,596	0	0		2.00
	TOTALS		28,178	0			
500.00	Grand Total: Decreases		66,789	393,200			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 2/26/2024 1:42 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	332,950	0	0	0	0	1.00
2.00	Land Improvements	483,750	0	0	0	0	2.00
3.00	Buildings and Fixtures	26,876,675	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	16,726,644	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	44,420,019	0	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	44,420,019	0	0	0	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	332,950	0	1.00
2.00	Land Improvements	483,750	0	2.00
3.00	Buildings and Fixtures	26,876,675	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	16,726,644	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	44,420,019	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	44,420,019	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 2/26/2024 1:42 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	307,649	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	307,649	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	307,649		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	307,649		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 2/26/2024 1:42 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	27,360,425	0	27,360,425	0.620600	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	16,726,644	0	16,726,644	0.379400	0	2.00
3.00	Total (sum of lines 1-2)	44,087,069	0	44,087,069	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	178,437	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	129,212	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	307,649	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	32,062	0	0	0	210,499	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	23,216	0	0	0	152,428	2.00
3.00	Total (sum of lines 1-2)	55,278	0	0	0	362,927	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/26/2024 1:42 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		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	-2,233	COMMUNICATIONS	5.04	0	7.00
8.00	Television and radio service (chapter 21)	A	-2,065	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-460,580			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-32,967	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		0		0.00	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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/26/2024 1:42 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	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	NON-PATIENT REVENUE	B	-19,249	OTHER ADMINISTRATIVE & GENERAL	5.06	0	33.01
33.02	NON-PATIENT REVENUE	B	-178	HOSPICE	116.00	0	33.02
33.03	NON-PATIENT REVENUE	B	10	DRUGS CHARGED TO PATIENTS	73.00	0	33.03
33.04	NON-PATIENT REVENUE	B	-37	MEDICAL RECORDS & LIBRARY	16.00	0	33.04
33.05	NON-PATIENT REVENUE	B	-3,245	DIETARY	10.00	0	33.05
33.06	NON-PATIENT REVENUE	B	-3,378	RURAL HEALTH CLINIC	88.00	0	33.06
33.07	RENTAL INCOME	B	-15,650	CLINIC	90.00	0	33.07
33.08	RENTAL INCOME	B	321	OTHER ADMINISTRATIVE & GENERAL	5.06	0	33.08
33.09	MARKETING EXPENSES	A	-490	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	MARKETING EXPENSES	A	1	PURCHASING RECEIVING AND STORES	5.02	0	33.10
33.11	MARKETING EXPENSES	A	-16,880	OTHER ADMINISTRATIVE & GENERAL	5.06	0	33.11
33.12	MARKETING EXPENSES	A	10	CLINIC	90.00	0	33.12
33.13	MARKETING EXPENSES	A	2	HOSPICE	116.00	0	33.13
33.14	PHYSICIAN RECRUITMENT	A	4	OTHER ADMINISTRATIVE & GENERAL	5.06	0	33.14
33.15	OUTREACH EXPENSES	A	-5,897	OTHER ADMINISTRATIVE & GENERAL	5.06	0	33.15
33.16	MARKETING EXPENSES	A	-5,958	ST ANNE CLINIC	90.01	0	33.16
33.17	BUSINESS OFFICE INCOME	A	-264	BUSINESS OFFICE	5.05	0	33.17
33.18	COGS	A	-590	PURCHASING RECEIVING AND STORES	5.02	0	33.18
33.19	NURSING HOME BED TAX	A	-13,760	SKILLED NURSING FACILITY	44.00	0	33.19
33.20	INVENTORY ADJ SPLIT BTW PPS & CAH	A	618,646	OTHER ADMINISTRATIVE & GENERAL	5.06	0	33.20
33.21	INVENTORY ADJ SPLIT BTW PPS & CAH	A	27	NURSING ADMINISTRATION	13.00	0	33.21
33.22	INVENTORY ADJ SPLIT BTW PPS & CAH	A	159	SKILLED NURSING FACILITY	44.00	0	33.22
33.23	INVENTORY ADJ SPLIT BTW PPS & CAH	A	256	PHYSICAL THERAPY	66.00	0	33.23
33.24	INVENTORY ADJ SPLIT BTW PPS & CAH	A	82,396	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	33.24
33.25	INVENTORY ADJ SPLIT BTW PPS & CAH	A	54	ST ANNE CLINIC	90.01	0	33.25
33.26	INVENTORY ADJ SPLIT BTW PPS & CAH	A	70	EMERGENCY	91.00	0	33.26
34.00	HOSPITAL MEDICAID ASSESSMENT	A	-259,506	OTHER ADMINISTRATIVE & GENERAL	5.06	0	34.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-140,971				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 2/26/2024 1:42 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	91.00	EMERGENCY	455,629	121,243	334,386	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	167,832	167,832	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	47,682	47,682	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	8,811	8,811	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	60.00	LABORATORY	1,792	1,792	0	0	0	7.00
8.00	90.00	CLINIC	63,555	63,555	0	0	0	8.00
9.00	90.01	ST ANNE CLINIC	49,665	49,665	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			794,966	460,580	334,386		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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	90.01	ST ANNE CLINIC	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	91.00	EMERGENCY	0	0	0	121,243		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	167,832		2.00
3.00	0.00		0	0	0	0		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	47,682		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	8,811		5.00
6.00	0.00		0	0	0	0		6.00
7.00	60.00	LABORATORY	0	0	0	1,792		7.00
8.00	90.00	CLINIC	0	0	0	63,555		8.00
9.00	90.01	ST ANNE CLINIC	0	0	0	49,665		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	460,580		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/26/2024 1:42 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	ADMITTING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	210,499	210,499				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	152,428		152,428			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,103,649	2,713	354	1,106,716		4.00
5.01	00570	ADMITTING	58,978	1,285	300	19,545	80,108	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	14,712	1,466	201	5,335	0	5.02
5.03	00550	DATA PROCESSING	125,340	3,754	9,668	16,250	0	5.03
5.04	01160	COMMUNICATIONS	29,819	270	0	0	0	5.04
5.05	00590	BUSINESS OFFICE	99,891	13,746	88	19,205	0	5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	205,126	11,129	1,331	65,858	0	5.06
7.00	00700	OPERATION OF PLANT	333,702	22,546	18,428	26,801	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,546	3,485	19	5,229	0	8.00
9.00	00900	HOUSEKEEPING	72,343	1,016	21	24,226	0	9.00
10.00	01000	DIETARY	68,442	5,078	355	8,263	0	10.00
11.00	01100	CAFETERIA	86,135	1,580	0	13,266	0	11.00
13.00	01300	NURSING ADMINISTRATION	33,549	1,615	0	11,513	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,326	2,286	1,047	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	38,330	2,043	13	11,879	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	506,532	14,104	8,753	56,047	4,451	30.00
44.00	04400	SKILLED NURSING FACILITY	360,274	14,873	4,263	106,460	3,797	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	185,862	24,746	37,197	37,713	11,258	50.00
53.00	05300	ANESTHESIOLOGY	6,580	167	125	0	155	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	283,643	8,346	34,279	50,524	19,417	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	282,805	5,349	3,823	57,341	14,357	60.00
65.00	06500	RESPIRATORY THERAPY	107,405	3,117	2,775	32,617	593	65.00
66.00	06600	PHYSICAL THERAPY	308,610	18,780	5,312	53,839	4,519	66.00
69.00	06900	ELECTROCARDIOLOGY	936	1,106	1,138	0	527	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-899	0	0	0	1,564	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,686	0	0	0	217	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	495,963	5,349	887	37,853	6,369	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	76,398	2,002	96	25,385	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	91,320	4,264	3,332	27,017	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	215,874	6,470	1,738	69,961	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	408,852	3,665	2,784	132,931	1,390	88.03
90.00	09000	CLINIC	30,205	9,883	655	11,370	1,305	90.00
90.01	09001	ST ANNE CLINIC	13,558	2,282	169	15,694	0	90.01
91.00	09100	EMERGENCY	708,270	7,020	5,460	91,261	10,189	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	113,259	3,570	3,166	36,406	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	240,701	0	3,224	33,732	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,099,649	209,105	151,001	1,103,521	80,108	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	1,394	0	0	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	16,884	0	918	3,195	0	194.01
194.02	07952	REFERENCE LAB	0	0	509	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,116,533	210,499	152,428	1,106,716	80,108	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/26/2024 1:42 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES	DATA PROCESSING	COMMUNICATIONS	BUSINESS OFFICE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	21,714					5.02
5.03	00550	DATA PROCESSING	0	155,012				5.03
5.04	01160	COMMUNICATIONS	0	0	30,089			5.04
5.05	00590	BUSINESS OFFICE	16	4,795	382	138,123		5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	0	5,268	2,675	0	291,387	5.06
7.00	00700	OPERATION OF PLANT	1,430	4,668	764	0	408,339	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	160	684	96	0	25,219	8.00
9.00	00900	HOUSEKEEPING	64	7,360	96	0	105,126	9.00
10.00	01000	DIETARY	0	4,556	0	0	86,694	10.00
11.00	01100	CAFETERIA	0	3,769	0	0	104,750	11.00
13.00	01300	NURSING ADMINISTRATION	1	2,829	191	0	49,698	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	107	0	0	0	4,766	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5	4,953	382	0	57,605	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	548	15,313	4,490	7,443	617,681	30.00
44.00	04400	SKILLED NURSING FACILITY	3,006	17,148	1,051	6,349	517,221	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	440	7,007	2,770	18,827	325,820	50.00
53.00	05300	ANESTHESIOLOGY	15	0	0	259	7,301	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	445	9,065	1,433	32,488	439,640	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	130	8,307	1,433	24,011	397,556	60.00
65.00	06500	RESPIRATORY THERAPY	480	4,873	573	991	153,424	65.00
66.00	06600	PHYSICAL THERAPY	10,970	5,369	1,337	7,557	416,293	66.00
69.00	06900	ELECTROCARDIOLOGY	0	658	0	882	5,247	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,616	3,281	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,101	0	0	363	15,367	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25	3,729	573	10,651	561,399	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	122	2,935	573	1,169	108,680	88.00
88.01	08801	RURAL HEALTH CLINIC II	254	2,459	1,146	1,225	131,017	88.01
88.02	08802	RURAL HEALTH CLINIC III	63	4,364	2,292	1,581	302,343	88.02
88.03	08803	RURAL HEALTH CLINIC IV	237	4,869	2,101	2,325	559,154	88.03
90.00	09000	CLINIC	86	3,642	1,242	2,183	60,571	90.00
90.01	09001	ST ANNE CLINIC	242	0	955	164	33,064	90.01
91.00	09100	EMERGENCY	1,606	9,346	1,624	17,039	851,815	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	128	4,087	573	0	161,189	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	8,732	955	0	287,344	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,681	150,785	29,707	138,123	7,088,991	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	1,394	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	33	4,180	382	0	25,592	194.01
194.02	07952	REFERENCE LAB	0	47	0	0	556	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,714	155,012	30,089	138,123	7,116,533	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/26/2024 1:42 pm

		Cost Center Description	OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	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
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	DATA PROCESSING						5.03
5.04	01160	COMMUNICATIONS						5.04
5.05	00590	BUSINESS OFFICE						5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	291,387					5.06
7.00	00700	OPERATION OF PLANT	17,433	425,772				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,077	9,660	35,956			8.00
9.00	00900	HOUSEKEEPING	4,488	2,817	0	112,431		9.00
10.00	01000	DIETARY	3,701	14,077	0	4,258	108,730	10.00
11.00	01100	CAFETERIA	4,472	4,379	0	1,325	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,122	4,476	0	1,354	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	203	6,338	0	1,917	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,459	5,664	0	1,713	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,371	39,099	6,707	11,828	14,264	30.00
44.00	04400	SKILLED NURSING FACILITY	22,082	41,230	13,078	12,472	93,996	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,910	68,604	3,077	20,754	63	50.00
53.00	05300	ANESTHESIOLOGY	312	463	0	140	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,770	23,135	2,619	6,999	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	16,973	14,827	58	4,485	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,550	8,641	0	2,614	0	65.00
66.00	06600	PHYSICAL THERAPY	17,773	52,060	1,382	15,749	0	66.00
69.00	06900	ELECTROCARDIOLOGY	224	3,066	0	927	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	140	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	656	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,968	14,827	0	4,485	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,640	5,550	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,594	11,820	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	12,908	17,935	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	23,872	10,161	0	3,074	0	88.03
90.00	09000	CLINIC	2,586	27,397	255	8,288	125	90.00
90.01	09001	ST ANNE CLINIC	1,412	6,325	0	0	0	90.01
91.00	09100	EMERGENCY	36,364	19,459	8,780	5,886	282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	6,882	9,896	0	2,994	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	12,268	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	290,210	421,906	35,956	111,262	108,730	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	60	3,866	0	1,169	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	1,093	0	0	0	0	194.01
194.02	07952	REFERENCE LAB	24	0	0	0	0	194.02
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)	291,387	425,772	35,956	112,431	108,730	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/26/2024 1:42 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	14.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	DATA PROCESSING						5.03
5.04	01160	COMMUNICATIONS						5.04
5.05	00590	BUSINESS OFFICE						5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL						5.06
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	114,926					11.00
13.00	01300	NURSING ADMINISTRATION	1,541	59,191				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	13,224			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,852	0	4	71,297		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,074	16,130	364	3,842	747,360	30.00
44.00	04400	SKILLED NURSING FACILITY	26,190	0	1,994	3,277	731,540	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,874	8,556	292	9,718	456,668	50.00
53.00	05300	ANESTHESIOLOGY	0	0	10	134	8,360	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,700	0	295	16,769	519,927	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	13,433	0	86	12,394	459,812	60.00
65.00	06500	RESPIRATORY THERAPY	7,896	11,502	319	512	191,458	65.00
66.00	06600	PHYSICAL THERAPY	10,737	0	7,275	3,901	525,170	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	455	9,919	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,350	4,771	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	730	187	16,940	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,548	0	17	5,498	616,742	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	81	603	119,554	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	168	633	149,232	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	42	816	334,044	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	157	1,200	597,618	88.03
90.00	09000	CLINIC	1,733	2,525	57	1,127	104,664	90.00
90.01	09001	ST ANNE CLINIC	0	0	161	85	41,047	90.01
91.00	09100	EMERGENCY	14,059	20,478	1,065	8,796	966,984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	85	0	181,046	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	299,612	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,637	59,191	13,202	71,297	7,082,468	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	6,489	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	289	0	22	0	26,996	194.01
194.02	07952	REFERENCE LAB	0	0	0	0	580	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	114,926	59,191	13,224	71,297	7,116,533	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet B Part I Date/Time Prepared: 2/26/2024 1:42 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00550	DATA PROCESSING				5.03
5.04	01160	COMMUNICATIONS				5.04
5.05	00590	BUSINESS OFFICE				5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL				5.06
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
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	747,360		30.00
44.00	04400	SKILLED NURSING FACILITY	0	731,540		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	456,668		50.00
53.00	05300	ANESTHESIOLOGY	0	8,360		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	519,927		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	459,812		60.00
65.00	06500	RESPIRATORY THERAPY	0	191,458		65.00
66.00	06600	PHYSICAL THERAPY	0	525,170		66.00
69.00	06900	ELECTROCARDIOLOGY	0	9,919		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,771		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,940		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	616,742		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	119,554		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	149,232		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	334,044		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	597,618		88.03
90.00	09000	CLINIC	0	104,664		90.00
90.01	09001	ST ANNE CLINIC	0	41,047		90.01
91.00	09100	EMERGENCY	0	966,984		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	181,046		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	299,612		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7,082,468		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	6,489		190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	26,996		194.01
194.02	07952	REFERENCE LAB	0	580		194.02
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,116,533		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/26/2024 1:42 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	2,713	354	3,067	3,067	4.00
5.01	00570	ADMITTING	0	1,285	300	1,585	54	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	1,466	201	1,667	15	5.02
5.03	00550	DATA PROCESSING	0	3,754	9,668	13,422	45	5.03
5.04	01160	COMMUNICATIONS	0	270	0	270	0	5.04
5.05	00590	BUSINESS OFFICE	0	13,746	88	13,834	53	5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	0	11,129	1,331	12,460	182	5.06
7.00	00700	OPERATION OF PLANT	0	22,546	18,428	40,974	74	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,485	19	3,504	14	8.00
9.00	00900	HOUSEKEEPING	0	1,016	21	1,037	67	9.00
10.00	01000	DIETARY	0	5,078	355	5,433	23	10.00
11.00	01100	CAFETERIA	0	1,580	0	1,580	37	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,615	0	1,615	32	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,286	1,047	3,333	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,043	13	2,056	33	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	14,104	8,753	22,857	155	30.00
44.00	04400	SKILLED NURSING FACILITY	0	14,873	4,263	19,136	295	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	24,746	37,197	61,943	104	50.00
53.00	05300	ANESTHESIOLOGY	0	167	125	292	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,346	34,279	42,625	140	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	5,349	3,823	9,172	159	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,117	2,775	5,892	90	65.00
66.00	06600	PHYSICAL THERAPY	0	18,780	5,312	24,092	149	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,106	1,138	2,244	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	5,349	887	6,236	105	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,002	96	2,098	70	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,264	3,332	7,596	75	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	6,470	1,738	8,208	194	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	3,665	2,784	6,449	371	88.03
90.00	09000	CLINIC	0	9,883	655	10,538	32	90.00
90.01	09001	ST ANNE CLINIC	0	2,282	169	2,451	43	90.01
91.00	09100	EMERGENCY	0	7,020	5,460	12,480	253	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	3,570	3,166	6,736	101	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	3,224	3,224	93	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	209,105	151,001	360,106	3,058	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	1,394	0	1,394	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	0	918	918	9	194.01
194.02	07952	REFERENCE LAB	0	0	509	509	0	194.02
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	210,499	152,428	362,927	3,067	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/26/2024 1:42 pm

		Cost Center Description	ADMITTING	PURCHASING RECEIVING AND STORES	DATA PROCESSING	COMMUNICATIONS	BUSINESS OFFICE	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	1,639					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	1,682				5.02
5.03	00550	DATA PROCESSING	0	0	13,467			5.03
5.04	01160	COMMUNICATIONS	0	0	0	270		5.04
5.05	00590	BUSINESS OFFICE	0	1	417	3	14,308	5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	0	0	458	24	0	5.06
7.00	00700	OPERATION OF PLANT	0	111	406	7	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12	59	1	0	8.00
9.00	00900	HOUSEKEEPING	0	5	639	1	0	9.00
10.00	01000	DIETARY	0	0	396	0	0	10.00
11.00	01100	CAFETERIA	0	0	327	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	246	2	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	430	3	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	91	42	1,330	40	771	30.00
44.00	04400	SKILLED NURSING FACILITY	78	233	1,490	9	658	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	230	34	609	25	1,950	50.00
53.00	05300	ANESTHESIOLOGY	3	1	0	0	27	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	400	34	788	13	3,365	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	293	10	722	13	2,487	60.00
65.00	06500	RESPIRATORY THERAPY	12	37	423	5	103	65.00
66.00	06600	PHYSICAL THERAPY	92	852	466	12	783	66.00
69.00	06900	ELECTROCARDIOLOGY	11	0	57	0	91	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32	0	0	0	271	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4	85	0	0	38	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	130	2	324	5	1,103	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	9	255	5	121	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	20	214	10	127	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	5	379	21	164	88.02
88.03	08803	RURAL HEALTH CLINIC IV	28	18	423	19	241	88.03
90.00	09000	CLINIC	27	7	316	11	226	90.00
90.01	09001	ST ANNE CLINIC	0	19	0	9	17	90.01
91.00	09100	EMERGENCY	208	124	812	15	1,765	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	10	355	5	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	759	9	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,639	1,679	13,100	267	14,308	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	3	363	3	0	194.01
194.02	07952	REFERENCE LAB	0	0	4	0	0	194.02
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)	1,639	1,682	13,467	270	14,308	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/26/2024 1:42 pm

		Cost Center Description	OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	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
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	DATA PROCESSING						5.03
5.04	01160	COMMUNICATIONS						5.04
5.05	00590	BUSINESS OFFICE						5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	13,124					5.06
7.00	00700	OPERATION OF PLANT	785	42,357				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	48	961	4,599			8.00
9.00	00900	HOUSEKEEPING	202	280	0	2,231		9.00
10.00	01000	DIETARY	167	1,400	0	85	7,504	10.00
11.00	01100	CAFETERIA	201	436	0	26	0	11.00
13.00	01300	NURSING ADMINISTRATION	96	445	0	27	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9	630	0	38	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	111	563	0	34	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,188	3,890	858	235	984	30.00
44.00	04400	SKILLED NURSING FACILITY	995	4,102	1,672	247	6,488	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	627	6,826	394	413	4	50.00
53.00	05300	ANESTHESIOLOGY	14	46	0	3	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	845	2,302	335	139	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	765	1,475	7	89	0	60.00
65.00	06500	RESPIRATORY THERAPY	295	860	0	52	0	65.00
66.00	06600	PHYSICAL THERAPY	801	5,179	177	312	0	66.00
69.00	06900	ELECTROCARDIOLOGY	10	305	0	18	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,080	1,475	0	89	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	209	552	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	252	1,176	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	581	1,784	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,075	1,011	0	61	0	88.03
90.00	09000	CLINIC	116	2,725	33	164	9	90.00
90.01	09001	ST ANNE CLINIC	64	629	0	0	0	90.01
91.00	09100	EMERGENCY	1,636	1,936	1,123	117	19	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	310	984	0	59	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	553	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,071	41,972	4,599	2,208	7,504	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	3	385	0	23	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	49	0	0	0	0	194.01
194.02	07952	REFERENCE LAB	1	0	0	0	0	194.02
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)	13,124	42,357	4,599	2,231	7,504	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/26/2024 1:42 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	14.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	DATA PROCESSING						5.03
5.04	01160	COMMUNICATIONS						5.04
5.05	00590	BUSINESS OFFICE						5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL						5.06
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	2,607					11.00
13.00	01300	NURSING ADMINISTRATION	35	2,498				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	4,018			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	87	0	1	3,318		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	251	681	111	179	33,663	30.00
44.00	04400	SKILLED NURSING FACILITY	594	0	606	153	36,756	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	133	361	89	452	74,194	50.00
53.00	05300	ANESTHESIOLOGY	0	0	3	6	395	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	265	0	90	780	52,121	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	305	0	26	577	16,100	60.00
65.00	06500	RESPIRATORY THERAPY	179	485	97	24	8,554	65.00
66.00	06600	PHYSICAL THERAPY	244	0	2,208	182	35,549	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	21	2,757	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	63	372	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	222	9	388	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	149	0	5	256	10,959	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	25	28	3,372	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	51	29	9,550	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	13	38	11,387	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	48	56	9,800	88.03
90.00	09000	CLINIC	39	107	17	52	14,419	90.00
90.01	09001	ST ANNE CLINIC	0	0	49	4	3,285	90.01
91.00	09100	EMERGENCY	319	864	324	409	22,404	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	26	0	8,586	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	4,638	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,600	2,498	4,011	3,318	359,249	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	1,805	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	7	0	7	0	1,359	194.01
194.02	07952	REFERENCE LAB	0	0	0	0	514	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,607	2,498	4,018	3,318	362,927	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/26/2024 1:42 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00550	DATA PROCESSING				5.03
5.04	01160	COMMUNICATIONS				5.04
5.05	00590	BUSINESS OFFICE				5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL				5.06
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
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	33,663		30.00
44.00	04400	SKILLED NURSING FACILITY	0	36,756		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	74,194		50.00
53.00	05300	ANESTHESIOLOGY	0	395		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,121		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	16,100		60.00
65.00	06500	RESPIRATORY THERAPY	0	8,554		65.00
66.00	06600	PHYSICAL THERAPY	0	35,549		66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,757		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	372		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	388		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,959		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	3,372		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	9,550		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	11,387		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	9,800		88.03
90.00	09000	CLINIC	0	14,419		90.00
90.01	09001	ST ANNE CLINIC	0	3,285		90.01
91.00	09100	EMERGENCY	0	22,404		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	8,586		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	4,638		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	359,249		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	1,805		190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	1,359		194.01
194.02	07952	REFERENCE LAB	0	514		194.02
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	362,927		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/26/2024 1:42 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	138,573					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,356,007				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,786	3,146	3,221,124			4.00
5.01	00570	ADMITTING	846	2,667	56,886	13,523,496		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	965	1,789	15,529	0	270,019	5.02
5.03	00550	DATA PROCESSING	2,471	86,003	47,295	0	6	5.03
5.04	01160	COMMUNICATIONS	178	0	0	0	0	5.04
5.05	00590	BUSINESS OFFICE	9,049	783	55,898	0	198	5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	7,326	11,838	191,681	0	0	5.06
7.00	00700	OPERATION OF PLANT	14,842	163,936	78,004	0	17,778	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,294	169	15,218	0	1,994	8.00
9.00	00900	HOUSEKEEPING	669	189	70,510	0	793	9.00
10.00	01000	DIETARY	3,343	3,162	24,049	0	0	10.00
11.00	01100	CAFETERIA	1,040	0	38,611	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,063	0	33,510	0	12	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,505	9,318	0	0	1,326	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,345	112	34,574	0	66	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,285	77,871	163,125	751,314	6,820	30.00
44.00	04400	SKILLED NURSING FACILITY	9,791	37,928	309,853	640,881	37,378	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,292	330,898	109,765	1,900,363	5,477	50.00
53.00	05300	ANESTHESIOLOGY	110	1,108	0	26,126	181	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,494	304,953	147,051	3,278,586	5,538	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	3,521	34,012	166,893	2,423,593	1,611	60.00
65.00	06500	RESPIRATORY THERAPY	2,052	24,683	94,933	100,039	5,972	65.00
66.00	06600	PHYSICAL THERAPY	12,363	47,253	156,701	762,832	136,422	66.00
69.00	06900	ELECTROCARDIOLOGY	728	10,122	0	88,978	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	264,059	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	36,624	13,686	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,521	7,893	110,171	1,075,127	313	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,318	854	73,884	0	1,513	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,807	29,643	78,633	0	3,155	88.01
88.02	08802	RURAL HEALTH CLINIC III	4,259	15,457	203,622	0	785	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,413	24,770	386,903	234,680	2,942	88.03
90.00	09000	CLINIC	6,506	5,827	33,092	220,358	1,064	90.00
90.01	09001	ST ANNE CLINIC	1,502	1,502	45,678	0	3,009	90.01
91.00	09100	EMERGENCY	4,621	48,577	265,617	1,719,936	19,974	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	2,350	28,165	105,961	0	1,591	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	28,682	98,179	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	137,655	1,343,310	3,211,826	13,523,496	269,604	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	918	0	0	0	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	8,165	9,298	0	415	194.01
194.02	07952	REFERENCE LAB	0	4,532	0	0	0	194.02
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)	210,499	152,428	1,106,716	80,108	21,714	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.519048	0.112409	0.343581	0.005924	0.080417	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,067	1,639	1,682	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000952	0.000121	0.006229	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: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/26/2024 1:42 pm

		Cost Center Description	DATA PROCESSING (TIME SPENT)	COMMUNICATIONS (# OF PHONE S)	BUSINESS OFFICE (GROSS CHAR GES)	Reconciliation	OTHER ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	DATA PROCESSING	586,698					5.03
5.04	01160	COMMUNICATIONS	0	315				5.04
5.05	00590	BUSINESS OFFICE	18,147	4	13,941,383			5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL	19,939	28	0	-291,387	6,825,146	5.06
7.00	00700	OPERATION OF PLANT	17,669	8	0	0	408,339	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,590	1	0	0	25,219	8.00
9.00	00900	HOUSEKEEPING	27,858	1	0	0	105,126	9.00
10.00	01000	DIETARY	17,243	0	0	0	86,694	10.00
11.00	01100	CAFETERIA	14,267	0	0	0	104,750	11.00
13.00	01300	NURSING ADMINISTRATION	10,706	2	0	0	49,698	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	4,766	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,745	4	0	0	57,605	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	57,959	47	751,314	0	617,681	30.00
44.00	04400	SKILLED NURSING FACILITY	64,903	11	640,881	0	517,221	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,520	29	1,900,363	0	325,820	50.00
53.00	05300	ANESTHESIOLOGY	0	0	26,126	0	7,301	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,308	15	3,278,586	0	439,640	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	31,439	15	2,423,593	0	397,556	60.00
65.00	06500	RESPIRATORY THERAPY	18,445	6	100,039	0	153,424	65.00
66.00	06600	PHYSICAL THERAPY	20,322	14	762,832	0	416,293	66.00
69.00	06900	ELECTROCARDIOLOGY	2,490	0	88,978	0	5,247	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	264,059	0	3,281	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	36,624	0	15,367	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,112	6	1,075,127	0	561,399	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	11,110	6	118,008	0	108,680	88.00
88.01	08801	RURAL HEALTH CLINIC II	9,307	12	123,697	0	131,017	88.01
88.02	08802	RURAL HEALTH CLINIC III	16,518	24	159,595	0	302,343	88.02
88.03	08803	RURAL HEALTH CLINIC IV	18,427	22	234,680	0	559,154	88.03
90.00	09000	CLINIC	13,784	13	220,358	0	60,571	90.00
90.01	09001	ST ANNE CLINIC	0	10	16,587	0	33,064	90.01
91.00	09100	EMERGENCY	35,375	17	1,719,936	0	851,815	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	15,468	6	0	0	161,189	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	33,048	10	0	0	287,344	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	570,699	311	13,941,383	-291,387	6,797,604	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	1,394	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	15,820	4	0	0	25,592	194.01
194.02	07952	REFERENCE LAB	179	0	0	0	556	194.02
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)	155,012	30,089	138,123		291,387	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.264211	95.520635	0.009907		0.042693	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	13,467	270	14,308		13,124	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.022954	0.857143	0.001026		0.001923	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: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/26/2024 1:42 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			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
5.01	00570	ADMITTING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00550	DATA PROCESSING						5.03
5.04	01160	COMMUNICATIONS						5.04
5.05	00590	BUSINESS OFFICE						5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL						5.06
7.00	00700	OPERATION OF PLANT	101,110					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,294	24,715				8.00
9.00	00900	HOUSEKEEPING	669	0	88,261			9.00
10.00	01000	DIETARY	3,343	0	3,343	6,952		10.00
11.00	01100	CAFETERIA	1,040	0	1,040	0	11,935	11.00
13.00	01300	NURSING ADMINISTRATION	1,063	0	1,063	0	160	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,505	0	1,505	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,345	0	1,345	0	400	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,285	4,610	9,285	912	1,150	30.00
44.00	04400	SKILLED NURSING FACILITY	9,791	8,990	9,791	6,010	2,720	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,292	2,115	16,292	4	610	50.00
53.00	05300	ANESTHESIOLOGY	110	0	110	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,494	1,800	5,494	0	1,215	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	3,521	40	3,521	0	1,395	60.00
65.00	06500	RESPIRATORY THERAPY	2,052	0	2,052	0	820	65.00
66.00	06600	PHYSICAL THERAPY	12,363	950	12,363	0	1,115	66.00
69.00	06900	ELECTROCARDIOLOGY	728	0	728	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	3,521	0	3,521	0	680	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,318	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,807	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	4,259	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,413	0	2,413	0	0	88.03
90.00	09000	CLINIC	6,506	175	6,506	8	180	90.00
90.01	09001	ST ANNE CLINIC	1,502	0	0	0	0	90.01
91.00	09100	EMERGENCY	4,621	6,035	4,621	18	1,460	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	2,350	0	2,350	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100,192	24,715	87,343	6,952	11,905	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	918	0	918	0	0	190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	0	0	0	30	194.01
194.02	07952	REFERENCE LAB	0	0	0	0	0	194.02
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)	425,772	35,956	112,431	108,730	114,926	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.210978	1.454825	1.273847	15.640104	9.629326	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	42,357	4,599	2,231	7,504	2,607	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.418920	0.186081	0.025277	1.079402	0.218433	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: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/26/2024 1:42 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	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
5.01	00570	ADMITTING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00550	DATA PROCESSING					5.03
5.04	01160	COMMUNICATIONS					5.04
5.05	00590	BUSINESS OFFICE					5.05
5.06	00591	OTHER ADMINISTRATIVE & GENERAL					5.06
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	87,776				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	247,912			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	66	13,941,383		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	23,920	6,820	751,314		30.00
44.00	04400	SKILLED NURSING FACILITY	0	37,378	640,881		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	12,688	5,477	1,900,363		50.00
53.00	05300	ANESTHESIOLOGY	0	181	26,126		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,538	3,278,586		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	1,611	2,423,593		60.00
65.00	06500	RESPIRATORY THERAPY	17,056	5,972	100,039		65.00
66.00	06600	PHYSICAL THERAPY	0	136,422	762,832		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	88,978		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	264,059		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,686	36,624		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	313	1,075,127		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	1,513	118,008		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,155	123,697		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	785	159,595		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	2,942	234,680		88.03
90.00	09000	CLINIC	3,744	1,064	220,358		90.00
90.01	09001	ST ANNE CLINIC	0	3,009	16,587		90.01
91.00	09100	EMERGENCY	30,368	19,974	1,719,936		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	1,591	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87,776	247,497	13,941,383		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0		190.00
194.00	07950	IROQUOIS WOMENS HEALTH	0	0	0		194.00
194.01	07951	OTHER NONREIMBURSABLE DEPTS	0	415	0		194.01
194.02	07952	REFERENCE LAB	0	0	0		194.02
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)	59,191	13,224	71,297		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.674342	0.053342	0.005114		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,498	4,018	3,318		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.028459	0.016207	0.000238		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: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/26/2024 1:42 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	747,360		747,360	0	747,360	30.00
44.00	04400	SKILLED NURSING FACILITY	731,540		731,540	0	731,540	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	456,668		456,668	0	456,668	50.00
53.00	05300	ANESTHESIOLOGY	8,360		8,360	0	8,360	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	519,927		519,927	0	519,927	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	459,812		459,812	0	459,812	60.00
65.00	06500	RESPIRATORY THERAPY	191,458	0	191,458	0	191,458	65.00
66.00	06600	PHYSICAL THERAPY	525,170	0	525,170	0	525,170	66.00
69.00	06900	ELECTROCARDIOLOGY	9,919		9,919	0	9,919	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,771		4,771	0	4,771	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,940		16,940	0	16,940	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	616,742		616,742	0	616,742	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	119,554		119,554	0	119,554	88.00
88.01	08801	RURAL HEALTH CLINIC II	149,232		149,232	0	149,232	88.01
88.02	08802	RURAL HEALTH CLINIC III	334,044		334,044	0	334,044	88.02
88.03	08803	RURAL HEALTH CLINIC IV	597,618		597,618	0	597,618	88.03
90.00	09000	CLINIC	104,664		104,664	0	104,664	90.00
90.01	09001	ST ANNE CLINIC	41,047		41,047	0	41,047	90.01
91.00	09100	EMERGENCY	966,984		966,984	0	966,984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	309,932		309,932		309,932	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	181,046		181,046		181,046	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	299,612		299,612		299,612	116.00
200.00		Subtotal (see instructions)	7,392,400	0	7,392,400	0	7,392,400	200.00
201.00		Less Observation Beds	309,932		309,932		309,932	201.00
202.00		Total (see instructions)	7,082,468	0	7,082,468	0	7,082,468	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/26/2024 1:42 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	446,806		446,806			30.00
44.00	04400	SKILLED NURSING FACILITY	640,881		640,881			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,813	1,859,550	1,900,363	0.240306	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	26,126	26,126	0.319988	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	111,708	3,166,879	3,278,587	0.158583	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	72,468	2,351,124	2,423,592	0.189723	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	52,194	63,853	116,047	1.649832	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	18,228	744,604	762,832	0.688448	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	3,644	85,335	88,979	0.111476	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	58,339	205,720	264,059	0.018068	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,000	35,624	36,624	0.462538	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	114,789	960,338	1,075,127	0.573646	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	118,008	118,008			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	123,697	123,697			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	159,595	159,595			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	234,680	234,680			88.03
90.00	09000	CLINIC	1,000	219,358	220,358	0.474973	0.000000	90.00
90.01	09001	ST ANNE CLINIC	0	16,587	16,587	2.474649	0.000000	90.01
91.00	09100	EMERGENCY	5,000	1,698,928	1,703,928	0.567503	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,509	300,000	304,509	1.017809	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	166,387	166,387			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	411,523	411,523			116.00
200.00		Subtotal (see instructions)	1,571,379	12,947,916	14,519,295			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,571,379	12,947,916	14,519,295			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/26/2024 1:42 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
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.240306		50.00
53.00	05300	ANESTHESIOLOGY	0.319988		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158583		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.189723		60.00
65.00	06500	RESPIRATORY THERAPY	1.649832		65.00
66.00	06600	PHYSICAL THERAPY	0.688448		66.00
69.00	06900	ELECTROCARDIOLOGY	0.111476		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.018068		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.462538		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.573646		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
90.00	09000	CLINIC	0.474973		90.00
90.01	09001	ST ANNE CLINIC	2.474649		90.01
91.00	09100	EMERGENCY	0.567503		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.017809		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
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: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/26/2024 1:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	747,360		747,360	0	747,360	30.00
44.00	04400	SKILLED NURSING FACILITY	731,540		731,540	0	731,540	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	456,668		456,668	0	456,668	50.00
53.00	05300	ANESTHESIOLOGY	8,360		8,360	0	8,360	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	519,927		519,927	0	519,927	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	459,812		459,812	0	459,812	60.00
65.00	06500	RESPIRATORY THERAPY	191,458	0	191,458	0	191,458	65.00
66.00	06600	PHYSICAL THERAPY	525,170	0	525,170	0	525,170	66.00
69.00	06900	ELECTROCARDIOLOGY	9,919		9,919	0	9,919	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,771		4,771	0	4,771	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,940		16,940	0	16,940	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	616,742		616,742	0	616,742	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	119,554		119,554	0	119,554	88.00
88.01	08801	RURAL HEALTH CLINIC II	149,232		149,232	0	149,232	88.01
88.02	08802	RURAL HEALTH CLINIC III	334,044		334,044	0	334,044	88.02
88.03	08803	RURAL HEALTH CLINIC IV	597,618		597,618	0	597,618	88.03
90.00	09000	CLINIC	104,664		104,664	0	104,664	90.00
90.01	09001	ST ANNE CLINIC	41,047		41,047	0	41,047	90.01
91.00	09100	EMERGENCY	966,984		966,984	0	966,984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	309,932		309,932		309,932	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	181,046		181,046		181,046	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	299,612		299,612		299,612	116.00
200.00		Subtotal (see instructions)	7,392,400	0	7,392,400	0	7,392,400	200.00
201.00		Less Observation Beds	309,932		309,932		309,932	201.00
202.00		Total (see instructions)	7,082,468	0	7,082,468	0	7,082,468	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/26/2024 1:42 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	446,806		446,806			30.00
44.00	04400	SKILLED NURSING FACILITY	640,881		640,881			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,813	1,859,550	1,900,363	0.240306	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	26,126	26,126	0.319988	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	111,708	3,166,879	3,278,587	0.158583	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	72,468	2,351,124	2,423,592	0.189723	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	52,194	63,853	116,047	1.649832	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	18,228	744,604	762,832	0.688448	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	3,644	85,335	88,979	0.111476	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	58,339	205,720	264,059	0.018068	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,000	35,624	36,624	0.462538	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	114,789	960,338	1,075,127	0.573646	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	118,008	118,008	1.013101	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	123,697	123,697	1.206432	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	159,595	159,595	2.093073	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	234,680	234,680	2.546523	0.000000	88.03
90.00	09000	CLINIC	1,000	219,358	220,358	0.474973	0.000000	90.00
90.01	09001	ST ANNE CLINIC	0	16,587	16,587	2.474649	0.000000	90.01
91.00	09100	EMERGENCY	5,000	1,698,928	1,703,928	0.567503	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,509	300,000	304,509	1.017809	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	166,387	166,387			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	411,523	411,523			116.00
200.00		Subtotal (see instructions)	1,571,379	12,947,916	14,519,295			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,571,379	12,947,916	14,519,295			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/26/2024 1:42 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
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.240306		50.00
53.00	05300	ANESTHESIOLOGY	0.319988		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158583		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.189723		60.00
65.00	06500	RESPIRATORY THERAPY	1.649832		65.00
66.00	06600	PHYSICAL THERAPY	0.688448		66.00
69.00	06900	ELECTROCARDIOLOGY	0.111476		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.018068		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.462538		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.573646		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	1.013101		88.00
88.01	08801	RURAL HEALTH CLINIC II	1.206432		88.01
88.02	08802	RURAL HEALTH CLINIC III	2.093073		88.02
88.03	08803	RURAL HEALTH CLINIC IV	2.546523		88.03
90.00	09000	CLINIC	0.474973		90.00
90.01	09001	ST ANNE CLINIC	2.474649		90.01
91.00	09100	EMERGENCY	0.567503		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.017809		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
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: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet C Part II | Date/Time Prepared: 2/26/2024 1:42 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	456,668	74,194	382,474	0	0	50.00
53.00	05300	ANESTHESIOLOGY	8,360	395	7,965	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	519,927	52,121	467,806	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	459,812	16,100	443,712	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	191,458	8,554	182,904	0	0	65.00
66.00	06600	PHYSICAL THERAPY	525,170	35,549	489,621	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	9,919	2,757	7,162	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,771	372	4,399	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,940	388	16,552	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	616,742	10,959	605,783	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	119,554	3,372	116,182	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	149,232	9,550	139,682	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	334,044	11,387	322,657	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	597,618	9,800	587,818	0	0	88.03
90.00	09000	CLINIC	104,664	14,419	90,245	0	0	90.00
90.01	09001	ST ANNE CLINIC	41,047	3,285	37,762	0	0	90.01
91.00	09100	EMERGENCY	966,984	22,404	944,580	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	309,932	13,960	295,972	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	181,046	8,586	172,460	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	299,612	4,638	294,974	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	5,913,500	302,790	5,610,710	0	0	200.00
201.00		Less Observation Beds	309,932	13,960	295,972	0	0	201.00
202.00		Total (line 200 minus line 201)	5,603,568	288,830	5,314,738	0	0	202.00

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

Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet C Part II Date/Time Prepared: 2/26/2024 1:42 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	456,668	1,900,363	0.240306		50.00
53.00	05300	ANESTHESIOLOGY	8,360	26,126	0.319988		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	519,927	3,278,587	0.158583		54.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MRI	0	0	0.000000		58.00
60.00	06000	LABORATORY	459,812	2,423,592	0.189723		60.00
65.00	06500	RESPIRATORY THERAPY	191,458	116,047	1.649832		65.00
66.00	06600	PHYSICAL THERAPY	525,170	762,832	0.688448		66.00
69.00	06900	ELECTROCARDIOLOGY	9,919	88,979	0.111476		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,771	264,059	0.018068		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,940	36,624	0.462538		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	616,742	1,075,127	0.573646		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	119,554	118,008	1.013101		88.00
88.01	08801	RURAL HEALTH CLINIC II	149,232	123,697	1.206432		88.01
88.02	08802	RURAL HEALTH CLINIC III	334,044	159,595	2.093073		88.02
88.03	08803	RURAL HEALTH CLINIC IV	597,618	234,680	2.546523		88.03
90.00	09000	CLINIC	104,664	220,358	0.474973		90.00
90.01	09001	ST ANNE CLINIC	41,047	16,587	2.474649		90.01
91.00	09100	EMERGENCY	966,984	1,703,928	0.567503		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	309,932	304,509	1.017809		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY	181,046	166,387	1.088102		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	299,612	411,523	0.728057		116.00
200.00		Subtotal (sum of lines 50 thru 199)	5,913,500	13,431,608			200.00
201.00		Less Observation Beds	309,932	0			201.00
202.00		Total (line 200 minus line 201)	5,603,568	13,431,608			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/26/2024 1:42 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	74,194	1,900,363	0.039042	7,358	287	50.00
53.00	05300	ANESTHESIOLOGY	395	26,126	0.015119	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,121	3,278,587	0.015897	50,613	805	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	16,100	2,423,592	0.006643	35,097	233	60.00
65.00	06500	RESPIRATORY THERAPY	8,554	116,047	0.073712	577	43	65.00
66.00	06600	PHYSICAL THERAPY	35,549	762,832	0.046601	8,319	388	66.00
69.00	06900	ELECTROCARDIOLOGY	2,757	88,979	0.030985	421	13	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	372	264,059	0.001409	24,347	34	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	388	36,624	0.010594	697	7	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,959	1,075,127	0.010193	44,756	456	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,372	118,008	0.028574	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	9,550	123,697	0.077205	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	11,387	159,595	0.071349	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	9,800	234,680	0.041759	0	0	88.03
90.00	09000	CLINIC	14,419	220,358	0.065434	95	6	90.00
90.01	09001	ST ANNE CLINIC	3,285	16,587	0.198047	0	0	90.01
91.00	09100	EMERGENCY	22,404	1,703,928	0.013148	2,609	34	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	13,960	304,509	0.045844	1,578	72	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	289,566	12,853,698		176,467	2,378	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D Part III Date/Time Prepared: 2/26/2024 1:42 pm

Title XVIII | Hospital | Cost

		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
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
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	315	0.00	69	30.00
44.00	04400	SKILLED NURSING FACILITY		0	2,004	0.00	47	44.00
200.00		Total (lines 30 through 199)		0	2,319		116	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
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/26/2024 1:42 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
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ST ANNE CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/26/2024 1:42 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	1,900,363	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	26,126	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,278,587	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	2,423,592	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	116,047	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	762,832	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	88,979	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	264,059	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	36,624	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,075,127	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	118,008	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	123,697	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	159,595	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	234,680	0.000000	88.03
90.00	09000	CLINIC	0	0	0	220,358	0.000000	90.00
90.01	09001	ST ANNE CLINIC	0	0	0	16,587	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	1,703,928	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	304,509	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	12,853,698		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/26/2024 1:42 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	7,358	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	50,613	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	35,097	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	577	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	8,319	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	421	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	24,347	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	697	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	44,756	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	95	0	0	0	90.00
90.01	09001	ST ANNE CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	2,609	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,578	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		176,467	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/26/2024 1:42 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	0.240306	0	551,082	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.319988	0	6,199	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158583	0	950,992	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.189723	0	707,073	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.649832	0	35,708	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.688448	0	251,159	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.111476	0	20,020	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.018068	0	73,855	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.462538	0	7,337	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.573646	0	316,445	3,106	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
90.00	09000	CLINIC	0.474973	0	67,171	115	0	90.00
90.01	09001	ST ANNE CLINIC	2.474649	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.567503	0	359,807	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.017809	0	178,679	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	3,525,527	3,221	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	3,525,527	3,221	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/26/2024 1:42 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	132,428	0		50.00
53.00	05300	ANESTHESIOLOGY	1,984	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	150,811	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	134,148	0		60.00
65.00	06500	RESPIRATORY THERAPY	58,912	0		65.00
66.00	06600	PHYSICAL THERAPY	172,910	0		66.00
69.00	06900	ELECTROCARDIOLOGY	2,232	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,334	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,394	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	181,527	1,782		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
90.00	09000	CLINIC	31,904	55		90.00
90.01	09001	ST ANNE CLINIC	0	0		90.01
91.00	09100	EMERGENCY	204,192	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	181,861	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	1,257,637	1,837		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,257,637	1,837		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D Part I | Date/Time Prepared: 2/26/2024 1:42 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	33,663	2,198	31,465	315	99.89	30.00
44.00	SKILLED NURSING FACILITY	36,756		36,756	2,004	18.34	44.00
200.00	Total (lines 30 through 199)	70,419		68,221	2,319		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
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	0	0				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/26/2024 1:42 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	74,194	1,900,363	0.039042	0	0	50.00
53.00	05300	ANESTHESIOLOGY	395	26,126	0.015119	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,121	3,278,587	0.015897	0	0	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	16,100	2,423,592	0.006643	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,554	116,047	0.073712	0	0	65.00
66.00	06600	PHYSICAL THERAPY	35,549	762,832	0.046601	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,757	88,979	0.030985	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	372	264,059	0.001409	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	388	36,624	0.010594	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,959	1,075,127	0.010193	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,372	118,008	0.028574	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	9,550	123,697	0.077205	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	11,387	159,595	0.071349	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	9,800	234,680	0.041759	0	0	88.03
90.00	09000	CLINIC	14,419	220,358	0.065434	0	0	90.00
90.01	09001	ST ANNE CLINIC	3,285	16,587	0.198047	0	0	90.01
91.00	09100	EMERGENCY	22,404	1,703,928	0.013148	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	13,960	304,509	0.045844	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	289,566	12,853,698		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D Part III Date/Time Prepared: 2/26/2024 1:42 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
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
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	315	0.00	0	30.00
44.00	04400	SKILLED NURSING FACILITY		0	2,004	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	2,319		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
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/26/2024 1:42 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
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ST ANNE CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/26/2024 1:42 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	1,900,363	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	26,126	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,278,587	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	2,423,592	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	116,047	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	762,832	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	88,979	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	264,059	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	36,624	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,075,127	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	118,008	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	123,697	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	159,595	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	234,680	0.000000	88.03
90.00	09000	CLINIC	0	0	0	220,358	0.000000	90.00
90.01	09001	ST ANNE CLINIC	0	0	0	16,587	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	1,703,928	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	304,509	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	12,853,698		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D Part IV | Date/Time Prepared: 2/26/2024 1:42 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
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
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
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
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	ST ANNE CLINIC	0.000000	0	0	0	0	90.01
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/26/2024 1:42 pm

Title XIX | Hospital | PPS

		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	0.240306	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.319988	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158583	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.189723	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.649832	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.688448	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.111476	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.018068	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.462538	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.573646	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
90.00	09000	CLINIC	0.474973	0	0	0	0	90.00
90.01	09001	ST ANNE CLINIC	2.474649	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.567503	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.017809	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/26/2024 1:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
90.00	09000	CLINIC	0	0		90.00
90.01	09001	ST ANNE CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/26/2024 1:42 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)	367	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	315	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)	174	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	14	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)	8	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	30	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)	69	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)	14	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)	-14	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	220.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	220.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	747,360	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)	6,600	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)	54,958	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	692,402	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)	692,402	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,198.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	151,669	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)	151,669	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/26/2024 1:42 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)	52,747	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)	204,416	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)	30,773	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	-30,773	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)	141	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,198.10	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	309,932	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/26/2024 1:42 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	33,663	747,360	0.045043	309,932	13,960	90.00
91.00	Nursing Program cost	0	747,360	0.000000	309,932	0	91.00
92.00	Allied health cost	0	747,360	0.000000	309,932	0	92.00
93.00	All other Medical Education	0	747,360	0.000000	309,932	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1353 Component CCN: 14-6049	Period: From 07/17/2023 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/26/2024 1:42 pm
	Title XVIII	Skilled Nursing Facility	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)	2,004	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,004	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)	2,004	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)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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)	47	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)	731,540	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)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	731,540	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)	731,540	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1353 | Component CCN: 14-6049 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/26/2024 1:42 pm

Title XVIII | Skilled Nursing Facility | 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)		48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)		48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
55.01	Permanent adjustment amount per discharge		55.01
55.02	Adjustment amount per discharge (contractor use only)		55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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)		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)		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	731,540	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	365.04	71.00
72.00	Program routine service cost (line 9 x line 71)	17,157	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	17,157	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	17,157	83.00
84.00	Program inpatient ancillary services (see instructions)	322	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	17,479	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1353 Component CCN: 14-6049	Period: From 07/17/2023 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/26/2024 1:42 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	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	0	0	0.000000	0	0	90.00
91.00	Nursing Program cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/26/2024 1:42 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)	367	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	315	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)	174	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	14	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)	8	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	30	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)	747,360	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)	48,789	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	698,571	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)	698,571	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,217.69	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: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/26/2024 1:42 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)	141	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,217.69	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	312,694	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/26/2024 1:42 pm

Title XIX | Hospital | PPS

	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	33,663	747,360	0.045043	312,694	14,085	90.00
91.00	Nursing Program cost	0	747,360	0.000000	312,694	0	91.00
92.00	Allied health cost	0	747,360	0.000000	312,694	0	92.00
93.00	All other Medical Education	0	747,360	0.000000	312,694	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/26/2024 1:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		92,528		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.240306	7,358	1,768	50.00
53.00	05300	ANESTHESIOLOGY	0.319988	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158583	50,613	8,026	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.189723	35,097	6,659	60.00
65.00	06500	RESPIRATORY THERAPY	1.649832	577	952	65.00
66.00	06600	PHYSICAL THERAPY	0.688448	8,319	5,727	66.00
69.00	06900	ELECTROCARDIOLOGY	0.111476	421	47	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.018068	24,347	440	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.462538	697	322	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.573646	44,756	25,674	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	0.474973	95	45	90.00
90.01	09001	ST ANNE CLINIC	2.474649	0	0	90.01
91.00	09100	EMERGENCY	0.567503	2,609	1,481	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.017809	1,578	1,606	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		176,467	52,747	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)		176,467		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D-3

Component CCN: 14-Z353 | Date/Time Prepared: 2/26/2024 1:42 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	0.240306	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.319988	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158583	330	52	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.189723	1,207	229	60.00
65.00	06500	RESPIRATORY THERAPY	1.649832	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.688448	4,484	3,087	66.00
69.00	06900	ELECTROCARDIOLOGY	0.111476	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.018068	9,343	169	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.462538	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.573646	6,053	3,472	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	0.474973	0	0	90.00
90.01	09001	ST ANNE CLINIC	2.474649	0	0	90.01
91.00	09100	EMERGENCY	0.567503	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.017809	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		21,417	7,009	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)		21,417		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1353 | Component CCN: 14-6049 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/26/2024 1:42 pm

Title XVIII | Skilled Nursing Facility | PPS

		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	0.240306	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.319988	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158583	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.189723	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.649832	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.688448	467	322	66.00
69.00	06900	ELECTROCARDIOLOGY	0.111476	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.018068	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.462538	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.573646	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	0.474973	0	0	90.00
90.01	09001	ST ANNE CLINIC	2.474649	0	0	90.01
91.00	09100	EMERGENCY	0.567503	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.017809	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		467	322	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)		467		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/26/2024 1:42 pm

Title XIX | Hospital | PPS

		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		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.240306	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.319988	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158583	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.189723	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.649832	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.688448	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.111476	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.018068	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.462538	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.573646	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.013101	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.206432	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2.093073	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2.546523	0	0	88.03
90.00	09000	CLINIC	0.474973	0	0	90.00
90.01	09001	ST ANNE CLINIC	2.474649	0	0	90.01
91.00	09100	EMERGENCY	0.567503	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.017809	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/26/2024 1:42 pm

Title XVIII | Hospital | Cost

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	0	0	0	0	0	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	1,043,977	1,043,977	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	0	0	0	0	0	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	0	0	0	0	0	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/26/2024 1:42 pm

Title XVIII | Hospital | Cost

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	5,917	5,917	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	5,917	5,917	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	0	0	0	0	0	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	0	0	0	0	0	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet E Part B Date/Time Prepared: 2/26/2024 1:42 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,259,474	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)	1,259,474	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)	1,272,069	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)	409	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	566,258	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)	705,402	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)	705,402	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	705,402	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	705,402	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)	705,402	40.00
40.01	Sequestration adjustment (see instructions)	14,108	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	522,031	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)	169,263	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)	94,918	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: 14-1353	Period: From 07/17/2023 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/26/2024 1:42 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: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2024 1:42 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		276,182		522,031	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)		276,182		522,031	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		169,263	6.01
6.02	SETTLEMENT TO PROGRAM		97,313		0	6.02
7.00	Total Medicare program liability (see instructions)		178,869		691,294	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2024 1:42 pm

Component CCN: 14-Z353 | 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		28,063		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)		28,063		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		21,126		0	6.02
7.00	Total Medicare program liability (see instructions)		6,937		0	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: 14-1353 | Component CCN: 14-6049 | Period: From 07/17/2023 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2024 1:42 pm

Title XVIII | Skilled Nursing Facility | PPS

		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		23,339		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)		23,339		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		23,339		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1353	Period: From 07/17/2023 To 09/30/2023	Worksheet E-1 Part II Date/Time Prepared: 2/26/2024 1:42 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: 14-1353 | Component CCN: 14-Z353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet E-2 | Date/Time Prepared: 2/26/2024 1:42 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)	0	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)	7,079	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	0	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)	7,079	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	7,079	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)	7,079	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	7,079	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)	7,079	0	19.00
19.01	Sequestration adjustment (see instructions)	142	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	28,063	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)	-21,126	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: 14-1353	Period: From 07/17/2023 To 09/30/2023	Worksheet E-3 Part V Date/Time Prepared: 2/26/2024 1:42 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	204,416	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)	204,416	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	206,460	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)	206,460	19.00
20.00	Deductibles (exclude professional component)	23,941	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	182,519	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	182,519	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)	182,519	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)	182,519	30.00
30.01	Sequestration adjustment (see instructions)	3,650	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	276,182	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)	-97,313	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1353 Component CCN: 14-6049	Period: From 07/17/2023 To 09/30/2023	Worksheet E-3 Part VI Date/Time Prepared: 2/26/2024 1:42 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	24,215	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	24,215	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	400	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	23,815	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.98	Recovery of accelerated depreciation.	0	14.98
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	23,815	15.00
15.01	Sequestration adjustment (see instructions)	476	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)	0	15.75
16.00	Interim payments	23,339	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet E-3 Part VII Date/Time Prepared: 2/26/2024 1:42 pm

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 14-1353	Period: From 07/17/2023 To 09/30/2023	Worksheet E-5 Date/Time Prepared: 2/26/2024 1:42 pm
	Title XVIII		Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR		
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)	207,054	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2	17,120	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)	0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)	0	4.00
5.00	The rate used to calculate the time value of money (see instructions)	0.00	5.00
6.00	Time value of money for operating expenses (see instructions)	0	6.00
7.00	Time value of money for capital related expenses (see instructions)	0	7.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet G | Date/Time Prepared: 2/26/2024 1:42 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	3,590,533	0	0	0	1.00
2.00	Temporary investments	79,625	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	14,028,713	0	0	0	4.00
5.00	Other receivable	630,974	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-33,756	0	0	0	6.00
7.00	Inventory	1,615,728	0	0	0	7.00
8.00	Prepaid expenses	129,889	0	0	0	8.00
9.00	Other current assets	696,372	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)	20,738,078	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	332,950	0	0	0	12.00
13.00	Land improvements	483,750	0	0	0	13.00
14.00	Accumulated depreciation	-482,316	0	0	0	14.00
15.00	Buildings	25,787,398	0	0	0	15.00
16.00	Accumulated depreciation	-21,421,747	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	16,726,644	0	0	0	19.00
20.00	Accumulated depreciation	-16,992,641	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	968,885	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	5,402,923	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	478,839	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	6,079,148	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,557,987	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	32,698,988	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,741,325	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,307,679	0	0	0	38.00
39.00	Payroll taxes payable	482,684	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	3,126,453	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	-20,250	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,637,891	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,578,003	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	228,204	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,806,207	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,444,098	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	19,254,890				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)	19,254,890	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	32,698,988	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet G-1 | Date/Time Prepared: 2/26/2024 1:42 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		14,981,230		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,717,546				2.00
3.00	Total (sum of line 1 and line 2)		19,698,776		0		3.00
4.00	CHANGE IN UNRESTRICTED NET ASSETS	110,229		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)		110,229		0		10.00
11.00	Subtotal (line 3 plus line 10)		19,809,005		0		11.00
12.00	CHANGE IN DONOR RESTRICTED	554,115		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)		554,115		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		19,254,890		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	CHANGE IN UNRESTRICTED NET ASSETS		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	CHANGE IN DONOR RESTRICTED		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: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/26/2024 1:42 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	423,738		423,738	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	23,068		23,068	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	640,881		640,881	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,087,687		1,087,687	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,087,687		1,087,687	17.00
18.00	Ancillary services	473,183	9,499,153	9,972,336	18.00
19.00	Outpatient services	10,509	2,234,873	2,245,382	19.00
20.00	RURAL HEALTH CLINIC	0	118,008	118,008	20.00
20.01	RURAL HEALTH CLINIC II	0	123,697	123,697	20.01
20.02	RURAL HEALTH CLINIC III	0	159,595	159,595	20.02
20.03	RURAL HEALTH CLINIC IV	0	234,680	234,680	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		166,387	166,387	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	411,523	411,523	26.00
27.00	2532	2,532	352,573	355,105	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,573,911	13,300,489	14,874,400	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		7,257,504		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	PROVISION FOR BAD DEBTS	18,180			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)		18,180		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		7,239,324		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet G-3 | Date/Time Prepared: 2/26/2024 1:42 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	14,874,400	1.00
2.00	Less contractual allowances and discounts on patients' accounts	4,552,003	2.00
3.00	Net patient revenues (line 1 minus line 2)	10,322,397	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	7,239,324	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,083,073	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	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	32,967	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	37	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	15,650	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC NON-PATIENT REVENUE	1,370,296	24.00
24.01	OTHER MISCELLANOUS REVENUE	20,249	24.01
24.02	GRANT REVENUE	195,274	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,634,473	25.00
26.00	Total (line 5 plus line 25)	4,717,546	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)	4,717,546	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet H

HHA CCN: 14-7586 | Date/Time Prepared: 2/26/2024 1:42 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	37,390	0	0	0	6,416	43,806	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	50,427	0	0	0	0	50,427	6.00
7.00	Physical Therapy	13,783	0	0	0	0	13,783	7.00
8.00	Occupational Therapy	0	0	0	741	0	741	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	4,361	0	0	0	0	4,361	11.00
12.00	Supplies (see instructions)	0	0	0	0	648	648	12.00
13.00	Drugs	0	0	0	0	72	72	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	105,961	0	0	741	7,136	113,838	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-579	43,227	0	43,227			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	50,427	0	50,427			6.00
7.00	Physical Therapy	0	13,783	0	13,783			7.00
8.00	Occupational Therapy	0	741	0	741			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	4,361	0	4,361			11.00
12.00	Supplies (see instructions)	0	648	0	648			12.00
13.00	Drugs	0	72	0	72			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-579	113,259	0	113,259			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-1353 HHA CCN: 14-7586

Period: From 07/17/2023 To 09/30/2023

Worksheet H-1 Part I Date/Time Prepared: 2/26/2024 1:42 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	43,227	0	0	0	0	43,227	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	50,427	0	0	0	0	50,427	6.00
7.00	Physical Therapy	13,783	0	0	0	0	13,783	7.00
8.00	Occupational Therapy	741	0	0	0	0	741	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	4,361	0	0	0	0	4,361	11.00
12.00	Supplies (see instructions)	648	0	0	0	0	648	12.00
13.00	Drugs	72	0	0	0		72	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	113,259	0	0	0	0	113,259	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	43,227			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	31,126	81,553		6.00
7.00	Physical Therapy	8,508	22,291		7.00
8.00	Occupational Therapy	457	1,198		8.00
9.00	Speech Pathology	0	0		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Home Health Aide	2,692	7,053		11.00
12.00	Supplies (see instructions)	400	1,048		12.00
13.00	Drugs	44	116		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		113,259		24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-1353 HHA CCN: 14-7586

Period: From 07/17/2023 To 09/30/2023

Worksheet H-1 Part II Date/Time Prepared: 2/26/2024 1:42 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	2,350				0		1.00
2.00	Capital Related - Movable Equipment		28,165			0		2.00
3.00	Plant Operation & Maintenance	0	0	2,350		0		3.00
4.00	Transportation (see instructions)	0	0	0	100			4.00
5.00	Administrative and General	2,350	28,165	2,350	100	-43,227	70,032	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	50,427	6.00
7.00	Physical Therapy	0	0	0	0	0	13,783	7.00
8.00	Occupational Therapy	0	0	0	0	0	741	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	4,361	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	648	12.00
13.00	Drugs	0	0	0		0	72	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,350	28,165	2,350	100	-43,227	70,032	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		43,227	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.617246	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet H-2 Part I
HHA CCN: 14-7586 | Date/Time Prepared: 2/26/2024 1:42 pm

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	PURCHASING RECEIVING AND STORES	
		0	1.00	2.00	4.00	5.01	5.02	
1.00	Administrative and General	0	3,570	3,166	12,846	0	128	1.00
2.00	Skilled Nursing Care	81,553	0	0	17,326	0	0	2.00
3.00	Physical Therapy	22,291	0	0	4,736	0	0	3.00
4.00	Occupational Therapy	1,198	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	7,053	0	0	1,498	0	0	7.00
8.00	Supplies (see instructions)	1,048	0	0	0	0	0	8.00
9.00	Drugs	116	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	113,259	3,570	3,166	36,406	0	128	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	DATA PROCESSING	COMMUNICATIONS	BUSINESS OFFICE	Subtotal	OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		5.03	5.04	5.05	5A.05	5.06	7.00	
1.00	Administrative and General	4,087	573	0	24,370	1,040	9,896	1.00
2.00	Skilled Nursing Care	0	0	0	98,879	4,222	0	2.00
3.00	Physical Therapy	0	0	0	27,027	1,154	0	3.00
4.00	Occupational Therapy	0	0	0	1,198	51	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	8,551	365	0	7.00
8.00	Supplies (see instructions)	0	0	0	1,048	45	0	8.00
9.00	Drugs	0	0	0	116	5	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	4,087	573	0	161,189	6,882	9,896	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet H-2 Part I | Date/Time Prepared: 2/26/2024 1:42 pm

HHA CCN: 14-7586 | Home Health Agency I | PPS

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	2,994	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	85	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	2,994	0	0	0	85	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		16.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	38,300	0	38,300			1.00
2.00	Skilled Nursing Care	0	103,101	0	103,101	27,664	130,765	2.00
3.00	Physical Therapy	0	28,181	0	28,181	7,561	35,742	3.00
4.00	Occupational Therapy	0	1,249	0	1,249	335	1,584	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	8,916	0	8,916	2,392	11,308	7.00
8.00	Supplies (see instructions)	0	1,178	0	1,178	316	1,494	8.00
9.00	Drugs	0	121	0	121	32	153	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	181,046	0	181,046	38,300	181,046	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.268309		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1353
HHA CCN: 14-7586

Period:
From 07/17/2023
To 09/30/2023

Worksheet H-2
Part II
Date/Time Prepared:
2/26/2024 1:42 pm

Home Health Agency I

PPS

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	DATA PROCESSING (TIME SPENT)	
		1.00	2.00	4.00	5.01	5.02	5.03	
1.00	Administrative and General	2,350	28,165	37,390	0	1,591	15,468	1.00
2.00	Skilled Nursing Care	0	0	50,427	0	0	0	2.00
3.00	Physical Therapy	0	0	13,783	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	4,361	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	2,350	28,165	105,961	0	1,591	15,468	20.00
21.00	Total cost to be allocated	3,570	3,166	36,406	0	128	4,087	21.00
22.00	Unit cost multiplier	1.519149	0.112409	0.343579	0.000000	0.080453	0.264223	22.00

	Cost Center Description	COMMUNICATIONS (# OF PHONES)	BUSINESS OFFICE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5.04	5.05	5A.06	5.06	7.00	8.00	
1.00	Administrative and General	6	0	0	24,370	2,350	0	1.00
2.00	Skilled Nursing Care	0	0	0	98,879	0	0	2.00
3.00	Physical Therapy	0	0	0	27,027	0	0	3.00
4.00	Occupational Therapy	0	0	0	1,198	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	8,551	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	1,048	0	0	8.00
9.00	Drugs	0	0	0	116	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	6	0		161,189	2,350	0	20.00
21.00	Total cost to be allocated	573	0		6,882	9,896	0	21.00
22.00	Unit cost multiplier	95.500000	0.000000		0.042695	4.211064	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1353
HHA CCN: 14-7586

Period:
From 07/17/2023
To 09/30/2023

Worksheet H-2
Part II
Date/Time Prepared:
2/26/2024 1:42 pm

Home Health Agency I

PPS

	Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		9.00	10.00	11.00	13.00	14.00	16.00	
1.00	Administrative and General	2,350	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	1,591	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	2,350	0	0	0	1,591	0	20.00
21.00	Total cost to be allocated	2,994	0	0	0	85	0	21.00
22.00	Unit cost multiplier	1.274043	0.000000	0.000000	0.000000	0.053426	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet H-3 Part I | Date/Time Prepared: 2/26/2024 1:42 pm

HHA CCN: 14-7586 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	130,765		130,765	1,018	128.45	1.00
2.00	Physical Therapy	3.00	35,742	0	35,742	245	145.89	2.00
3.00	Occupational Therapy	4.00	1,584	0	1,584	32	49.50	3.00
4.00	Speech Pathology	5.00	0	0	0	0	0.00	4.00
5.00	Medical Social Services	6.00	0		0	1	0.00	5.00
6.00	Home Health Aide	7.00	11,308		11,308	206	54.89	6.00
7.00	Total (sum of lines 1-6)		179,399	0	179,399	1,502		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		19180	0	25			8.00
8.01	Skilled Nursing Care		99914	0	247			8.01
8.02	Skilled Nursing Care		16580	0	5			8.02
9.00	Physical Therapy		19180	0	0			9.00
9.01	Physical Therapy		99914	0	95			9.01
9.02	Physical Therapy		16580	0	6			9.02
10.00	Occupational Therapy		19180	0	0			10.00
10.01	Occupational Therapy		99914	0	20			10.01
10.02	Occupational Therapy		16580	0	1			10.02
11.00	Speech Pathology		19180	0	0			11.00
11.01	Speech Pathology		99914	0	0			11.01
11.02	Speech Pathology		16580	0	0			11.02
12.00	Medical Social Services		19180	0	0			12.00
12.01	Medical Social Services		99914	0	0			12.01
12.02	Medical Social Services		16580	0	0			12.02
13.00	Home Health Aide		19180	0	0			13.00
13.01	Home Health Aide		99914	0	124			13.01
13.02	Home Health Aide		16580	0	0			13.02
14.00	Total (sum of lines 8-13)			0	523			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	1,494	0	1,494	2,993	0.499165	15.00
16.00	Cost of Drugs	9.00	153	0	153	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	277		0	35,581		1.00
2.00	Physical Therapy	0	101		0	14,735		2.00
3.00	Occupational Therapy	0	21		0	1,040		3.00
4.00	Speech Pathology	0	0		0	0		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	124		0	6,806		6.00
7.00	Total (sum of lines 1-6)	0	523		0	58,162		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet H-3 Part I | Date/Time Prepared: 2/26/2024 1:42 pm

HHA CCN: 14-7586 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	2,993	0	0	1,494	0	15.00
16.00	Cost of Drugs	0	0			0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	35,581						1.00
2.00	Physical Therapy	14,735						2.00
3.00	Occupational Therapy	1,040						3.00
4.00	Speech Pathology	0						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	6,806						6.00
7.00	Total (sum of lines 1-6)	58,162						7.00

	Cost Center Description							
		12.00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1353
HHA CCN: 14-7586

Period:
From 07/17/2023
To 09/30/2023

Worksheet H-3
Part II
Date/Time Prepared:
2/26/2024 1:42 pm

Home Health Agency I

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		0	1.00	2.00	3.00	4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.688448	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy						2.00
3.00	Speech Pathology						3.00
4.00	Cost of Medical Supplies	71.00	0.018068	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.573646	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/26/2024 1:42 pm

HHA CCN: 14-7586 | Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	68,507	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	12,352	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	288	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	6,149	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	87,296	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	87,296	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	87,296	26.00
27.00	Allowable bad debts (from your records)		0	27.00
27.01	Adjusted reimbursable bad debts (see instructions)		0	27.01
28.00	Allowable bad debts for dual eligible (see instructions)		0	28.00
29.00	Total costs - current cost reporting period (see instructions)	0	87,296	29.00
30.00	ADJUSTMENT	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	87,296	31.00
31.01	Sequestration adjustment (see instructions)	0	1,746	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
31.75	Sequestration adjustment for non-claims based amounts (see instructions)	0	0	31.75
32.00	Interim payments (see instructions)	0	85,550	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-1353 HHA CCN: 14-7586

Period: From 07/17/2023 To 09/30/2023

Worksheet H-5

Date/Time Prepared: 2/26/2024 1:42 pm

Home Health Agency I

PPS

		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		0		85,550	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			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			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. H-4, Part II, column as appropriate, line 32)		0		85,550	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		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		85,550	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-1353 | Hospice CCN: 14-1616 | Period: From 07/17/2023 To 09/30/2023 | Worksheet O | Date/Time Prepared: 2/26/2024 1:42 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	12,768	22,958	35,726	-575	35,151	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	2,327	2,327	0	2,327	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	21	21	0	21	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		77,722	77,722	0	77,722	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	768	0	768	0	768	27.00
28.00	REGISTERED NURSE**	25,667	8,415	34,082	0	34,082	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	17,970	0	17,970	0	17,970	33.00
34.00	SPIRITUAL COUNSELING**	11,349	0	11,349	0	11,349	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	24,455	0	24,455	0	24,455	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	31,830	31,830	0	31,830	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	5,202	0	5,202	0	5,202	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	98,179	143,273	241,452	-575	240,877	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-1353 | Hospice CCN: 14-1616 | Period: From 07/17/2023 To 09/30/2023 | Worksheet O | Date/Time Prepared: 2/26/2024 1:42 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	-176	34,975		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	2,327		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	21		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	77,722		25.00
26.00	PHYSICIAN SERVICES**	0	0		26.00
27.00	NURSE PRACTITIONER**	0	768		27.00
28.00	REGISTERED NURSE**	0	34,082		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	17,970		33.00
34.00	SPIRITUAL COUNSELING**	0	11,349		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	24,455		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	31,830		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	5,202		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	-176	240,701		100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 14-1353 Hospice CCN: 14-1616

Period: From 07/17/2023 To 09/30/2023

Worksheet O-2

Date/Time Prepared: 2/26/2024 1:42 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	762	0	762	0	762	27.00
28.00	REGISTERED NURSE	25,451	8,345	33,796	0	33,796	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	17,819	0	17,819	0	17,819	33.00
34.00	SPIRITUAL COUNSELING	11,254	0	11,254	0	11,254	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	24,250	0	24,250	0	24,250	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	31,563	31,563	0	31,563	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	79,536	39,908	119,444	0	119,444	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	762		27.00
28.00	REGISTERED NURSE	0	33,796		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	17,819		33.00
34.00	SPIRITUAL COUNSELING	0	11,254		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	24,250		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	31,563		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	119,444		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE

Provider CCN: 14-1353 Hospice CCN: 14-1616

Period: From 07/17/2023 To 09/30/2023

Worksheet O-3

Date/Time Prepared: 2/26/2024 1:42 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		49,742	49,742	0	49,742	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	4	0	4	0	4	27.00
28.00	REGISTERED NURSE	138	45	183	0	183	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	97	0	97	0	97	33.00
34.00	SPIRITUAL COUNSELING	61	0	61	0	61	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	131	0	131	0	131	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	171	171	0	171	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	431	49,958	50,389	0	50,389	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	49,742		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	4		27.00
28.00	REGISTERED NURSE	0	183		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	97		33.00
34.00	SPIRITUAL COUNSELING	0	61		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	131		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	171		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	50,389		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE

Provider CCN: 14-1353 Hospice CCN: 14-1616

Period: From 07/17/2023 To 09/30/2023

Worksheet O-4

Date/Time Prepared: 2/26/2024 1:42 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		27,980	27,980	0	27,980	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	2	0	2	0	2	27.00
28.00	REGISTERED NURSE	78	25	103	0	103	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	54	0	54	0	54	33.00
34.00	SPIRITUAL COUNSELING	34	0	34	0	34	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	74	0	74	0	74	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	96	96	0	96	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	242	28,101	28,343	0	28,343	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	27,980		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	2		27.00
28.00	REGISTERED NURSE	0	103		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	54		33.00
34.00	SPIRITUAL COUNSELING	0	34		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	74		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	96		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	28,343		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 14-1353 Hospice CCN: 14-1616

Period: From 07/17/2023 To 09/30/2023

Worksheet O-5

Date/Time Prepared: 2/26/2024 1:42 pm

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,224	3,224	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	33,732	33,732	3.00
4.00	ADMINISTRATIVE & GENERAL	34,975	21,955	56,930	4.00
5.00	PLANT OPERATION & MAINTENANCE	2,327	0	2,327	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	21		21	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	119,444		119,444	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	50,389		50,389	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	28,343		28,343	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	5,202		5,202	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	240,701	58,911	299,612	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-1353 Hospice CCN: 14-1616

Period: From 07/17/2023 To 09/30/2023

Worksheet O-6 Part I Date/Time Prepared: 2/26/2024 1:42 pm

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,224		3,224			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	33,732	0	0	33,732		3.00
4.00	ADMINISTRATIVE & GENERAL	56,930	0	3,224	4,387	64,541	4.00
5.00	PLANT OPERATION & MAINTENANCE	2,327	0	0	0	2,327	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	21	0	0	0	21	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	119,444			27,327	146,771	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	50,389	0	0	148	50,537	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	28,343	0	0	83	28,426	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	5,202	0	0	1,787	6,989	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	299,612	0	3,224	33,732	299,612	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-1353 Hospice CCN: 14-1616

Period: From 07/17/2023 To 09/30/2023

Worksheet O-6 Part I Date/Time Prepared: 2/26/2024 1:42 pm

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	64,541					4.00
5.00	PLANT OPERATION & MAINTENANCE	639	2,966				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0		10.00
11.00	MEDICAL RECORDS	0	0		0		11.00
12.00	STAFF TRANSPORTATION	6	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	0	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	2,966		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	40,297					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	13,875	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	7,805	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	1,919	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	64,541	2,966	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-1353 Hospice CCN: 14-1616

Period: From 07/17/2023 To 09/30/2023

Worksheet O-6 Part I Date/Time Prepared: 2/26/2024 1:42 pm

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			27		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0	27	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	0	27	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-1353 Hospice CCN: 14-1616

Period: From 07/17/2023 To 09/30/2023

Worksheet O-6 Part I Date/Time Prepared: 2/26/2024 1:42 pm

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		2,966			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	2,941		190,036	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	16	0	64,428	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	9	0	36,240	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		8,908	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	2,966	0	299,612	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-1353
Hospice CCN: 14-1616

Period:
From 07/17/2023
To 09/30/2023

Worksheet O-6
Part II
Date/Time Prepared:
2/26/2024 1:42 pm

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	2,350					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		28,682				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	2,350	0	98,179			3.00
4.00	ADMINISTRATIVE & GENERAL	0	28,682	12,768	-64,541	235,071	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	2,327	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	21	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			79,535	0	146,771	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	431	0	50,537	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	243	0	28,426	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	5,202	0	6,989	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	3,224	33,732		64,541	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.112405	0.343577		0.274560	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-1353
Hospice CCN: 14-1616

Period:
From 07/17/2023
To 09/30/2023

Worksheet O-6
Part II
Date/Time Prepared:
2/26/2024 1:42 pm

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	2,350					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		2,350			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		2,976	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	2,350		2,350		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					2,951	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	16	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	9	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	2,966	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	1.262128	0.000000	0.000000	0.000000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-1353
Hospice CCN: 14-1616

Period:
From 07/17/2023
To 09/30/2023

Worksheet O-6
Part II
Date/Time Prepared:
2/26/2024 1:42 pm

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	2,976					10.00
11.00	MEDICAL RECORDS		2,976				11.00
12.00	STAFF TRANSPORTATION			2,976			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	2,951	2,951	2,951	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	16	16	16	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	9	9	9	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	27	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.009073	0.000000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-1353
Hospice CCN: 14-1616

Period:
From 07/17/2023
To 09/30/2023

Worksheet O-6
Part II
Date/Time Prepared:
2/26/2024 1:42 pm

Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		2,976			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	2,951			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	16	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	9	0		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	2,966	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.996640	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 14-1353 Hospice CCN: 14-1616

Period: From 07/17/2023 To 09/30/2023

Worksheet O-7

Date/Time Prepared: 2/26/2024 1:42 pm

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.688448	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.573646	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.189723	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.018068	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-1353 | Period: From 07/17/2023 To 09/30/2023 | Worksheet O-8

Hospice CCN: 14-1616 | Date/Time Prepared: 2/26/2024 1:42 pm

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			190,036	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			2,951	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			64.40	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	2,875	0		9.00
10.00	Program cost (line 8 times line 9)	185,150	0		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			64,428	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			16	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			4,026.75	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	16	0		14.00
15.00	Program cost (line 13 times line 14)	64,428	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			36,240	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			9	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			4,026.67	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	7	0		19.00
20.00	Program cost (line 18 times line 19)	28,187	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			290,704	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			2,976	22.00
23.00	Average cost per diem (line 21 divided by line 22)			97.68	23.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1353 | Component CCN: 14-3424 | Period: From 07/17/2023 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/26/2024 1:42 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	26,366	0	26,366	-10,932	15,434	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	30,677	0	30,677	-650	30,027	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	18,582	0	18,582	0	18,582	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)	75,625	0	75,625	-11,582	64,043	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	1,305	1,305	0	1,305	15.00
16.00	Transportation (Health Care Staff)	0	50	50	0	50	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	1,355	1,355	0	1,355	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	75,625	1,355	76,980	-11,582	65,398	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	2,800	2,800	0	2,800	29.00
30.00	Administrative Costs	9,841	3,165	13,006	-1,428	11,578	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	9,841	5,965	15,806	-1,428	14,378	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	85,466	7,320	92,786	-13,010	79,776	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1353 | Component CCN: 14-3424 | Period: From 07/17/2023 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/26/2024 1:42 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	0	15,434		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	30,027		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	18,582		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	64,043		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	1,305		15.00
16.00	Transportation (Health Care Staff)	0	50		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	1,355		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	65,398		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	2,800		29.00
30.00	Administrative Costs	-3,378	8,200		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-3,378	11,000		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-3,378	76,398		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1353 | Component CCN: 14-3425 | Period: From 07/17/2023 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/26/2024 1:42 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	17,581	0	17,581	10,932	28,513	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	22,653	0	22,653	650	23,303	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	20,141	0	20,141	0	20,141	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)	60,375	0	60,375	11,582	71,957	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	3,670	3,670	0	3,670	15.00
16.00	Transportation (Health Care Staff)	0	24	24	0	24	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	3,694	3,694	0	3,694	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	60,375	3,694	64,069	11,582	75,651	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	1,159	1,159	0	1,159	29.00
30.00	Administrative Costs	6,676	9,906	16,582	-2,072	14,510	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	6,676	11,065	17,741	-2,072	15,669	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	67,051	14,759	81,810	9,510	91,320	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1353 | Component CCN: 14-3425 | Period: From 07/17/2023 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/26/2024 1:42 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	28,513		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	23,303		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	20,141		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	71,957		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	3,670		15.00
16.00	Transportation (Health Care Staff)	0	24		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	3,694		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	75,651		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	1,159		29.00
30.00	Administrative Costs	0	14,510		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	15,669		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	91,320		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1353 | Component CCN: 15-3979 | Period: From 07/17/2023 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/26/2024 1:42 pm

RHC III | 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	130,985	0	130,985	0	130,985	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	16,596	16,596	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	45,549	0	45,549	0	45,549	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)	176,534	0	176,534	16,596	193,130	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	3,795	3,795	0	3,795	15.00
16.00	Transportation (Health Care Staff)	0	637	637	0	637	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	1,157	1,157	0	1,157	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	5,589	5,589	0	5,589	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	176,534	5,589	182,123	16,596	198,719	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	3,100	3,100	0	3,100	29.00
30.00	Administrative Costs	10,492	5,145	15,637	-1,582	14,055	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	10,492	8,245	18,737	-1,582	17,155	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	187,026	13,834	200,860	15,014	215,874	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1353 | Component CCN: 15-3979 | Period: From 07/17/2023 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/26/2024 1:42 pm

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	130,985		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	16,596		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	45,549		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	193,130		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	3,795		15.00
16.00	Transportation (Health Care Staff)	0	637		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	1,157		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	5,589		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	198,719		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	3,100		29.00
30.00	Administrative Costs	0	14,055		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	17,155		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	215,874		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1353 | Component CCN: 14-8551 | Period: From 07/17/2023 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/26/2024 1:42 pm

RHC IV | 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	227,576	63	227,639	0	227,639	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	66,177	0	66,177	-16,596	49,581	3.00
4.00	Visiting Nurse	62,423	0	62,423	0	62,423	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)	356,176	63	356,239	-16,596	339,643	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	5,374	5,374	0	5,374	15.00
16.00	Transportation (Health Care Staff)	0	179	179	0	179	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	5,553	5,553	0	5,553	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	356,176	5,616	361,792	-16,596	345,196	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	0	0	0	0	29.00
30.00	Administrative Costs	47,323	16,333	63,656	0	63,656	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	47,323	16,333	63,656	0	63,656	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	403,499	21,949	425,448	-16,596	408,852	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1353 | Component CCN: 14-8551 | Period: From 07/17/2023 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/26/2024 1:42 pm

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	227,639		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	49,581		3.00
4.00	Visiting Nurse	0	62,423		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)	0	339,643		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	5,374		15.00
16.00	Transportation (Health Care Staff)	0	179		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	5,553		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	345,196		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	0		29.00
30.00	Administrative Costs	0	63,656		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	63,656		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	408,852		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1353
Component CCN: 14-3424

Period:
From 07/17/2023
To 09/30/2023

Worksheet M-2

Date/Time Prepared:
2/26/2024 1:42 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	RHC I Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.07	293	2,200	154		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.16	555	2,100	336		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.23	848		490	848	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.23	848			848	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)					65,398	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)					65,398	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)					11,000	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					43,156	15.00
16.00	Total overhead (sum of lines 14 and 15)					54,156	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					54,156	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					54,156	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					119,554	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1353 | Component CCN: 14-3425 | Period: From 07/17/2023 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/26/2024 1:42 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.05	224	4,200	210		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.11	570	2,100	231		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.16	794		441	794	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.16	794			794	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)					75,651	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)					75,651	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)					15,669	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					57,912	15.00
16.00	Total overhead (sum of lines 14 and 15)					73,581	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					73,581	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					73,581	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					149,232	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1353
Component CCN: 15-3979
Period: From 07/17/2023 To 09/30/2023
Worksheet M-2
Date/Time Prepared: 2/26/2024 1:42 pm

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.18	1,049	2,800	504		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.18	302	2,100	378		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.36	1,351		882	1,351	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.36	1,351			1,351	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)					198,719	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)					198,719	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)					17,155	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					118,170	15.00
16.00	Total overhead (sum of lines 14 and 15)					135,325	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					135,325	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					135,325	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					334,044	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1353 | Component CCN: 14-8551 | Period: From 07/17/2023 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/26/2024 1:42 pm

RHC IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.16	771	3,000	480		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.20	1,072	2,100	420		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.36	1,843		900	1,843	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.36	1,843			1,843	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)					345,196	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)					345,196	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)					63,656	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					188,766	15.00
16.00	Total overhead (sum of lines 14 and 15)					252,422	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					252,422	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					252,422	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					597,618	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1353 | Component CCN: 14-3424 | Period: From 07/17/2023 To 09/30/2023 | Worksheet M-3 | Date/Time Prepared: 2/26/2024 1:42 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)			119,554	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			678	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			118,876	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			848	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)			848	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			140.18	7.00
		Calculation of Limit (1)			
		Rate Period N/A	Rate Period 1 (07/17/2023 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	263.63		8.00
9.00	Rate for Program covered visits (see instructions)	0.00	140.18		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	201		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	28,176		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	28,176		16.00
16.01	Total program charges (see instructions)(from contractor's records)		29,011		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,640		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,535		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.)		18,747		16.04
16.05	Total program cost (see instructions)	0	22,282		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,207		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		4,833		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		22,282		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		678		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		22,960		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)		22,960		26.00
26.01	Sequestration adjustment (see instructions)		459		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		33,827		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)		-11,326		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1353 Component CCN: 14-3425	Period: From 07/17/2023 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/26/2024 1:42 pm
	Title XVIII	RHC II	Cost

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	149,232	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	5,147	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	144,085	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	794	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)	794	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	181.47	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (07/17/2023 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	175.35	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	175.35	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	155	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	27,179	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	27,179	16.00
16.01	Total program charges (see instructions)(from contractor's records)		22,668	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,894	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		7,067	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.)		15,838	16.04
16.05	Total program cost (see instructions)	0	22,905	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		314	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		3,292	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		22,905	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,941	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		25,846	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)		25,846	26.00
26.01	Sequestration adjustment (see instructions)		517	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		21,783	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)		3,546	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1353 Component CCN: 15-3979	Period: From 07/17/2023 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/26/2024 1:42 pm
	Title XVIII	RHC III	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)	334,044	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	2,548	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	331,496	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	1,351	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	1,351	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	245.37	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (07/17/2023 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	307.59	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	245.37	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	354	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	86,861	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	86,861	16.00
16.01	Total program charges (see instructions)(from contractor's records)		58,587	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		8,806	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		13,056	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.)		57,450	16.04
16.05	Total program cost (see instructions)	0	70,506	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,993	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		9,557	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		70,506	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,593	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		72,099	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)		72,099	26.00
26.01	Sequestration adjustment (see instructions)		1,442	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		80,964	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)		-10,307	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1353 | Component CCN: 14-8551 | Period: From 07/17/2023 To 09/30/2023 | Worksheet M-3 | Date/Time Prepared: 2/26/2024 1:42 pm

Title XVIII | RHC IV | 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)	597,618	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	6,219	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	591,399	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	1,843	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	1,843	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	320.89	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (07/17/2023 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	176.70	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	176.70	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	425	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	75,098	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	75,098	16.00
16.01	Total program charges (see instructions)(from contractor's records)		57,400	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,837	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		8,945	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.)		51,677	16.04
16.05	Total program cost (see instructions)	0	60,622	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,557	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		9,801	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		60,622	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,783	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		63,405	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)		63,405	26.00
26.01	Sequestration adjustment (see instructions)		1,268	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		47,049	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)		15,088	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: 14-1353 | Component CCN: 14-3424 | Period: From 07/17/2023 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/26/2024 1:42 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)	64,043	64,043	64,043	64,043	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000158	0.000000	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	10	0	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	361	0	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	371	0	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	65,398	65,398	65,398	65,398	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	54,156	54,156	54,156	54,156	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.005673	0.000000	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	307	0	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	678	0	0	0	10.00
11.00	Total number of injections/infusions (from your records)	2	0	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	339.00	0.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	2	0	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)	678	0	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)		678	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)		678	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1353 | Component CCN: 14-3425 | Period: From 07/17/2023 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/26/2024 1:42 pm

Title XVIII | RHC II | 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)	71,957	71,957	71,957	71,957	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001106	0.000000	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	80	0	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	2,529	0	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,609	0	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	75,651	75,651	75,651	75,651	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	73,581	73,581	73,581	73,581	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.034487	0.000000	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2,538	0	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	5,147	0	0	0	10.00
11.00	Total number of injections/infusions (from your records)	14	0	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	367.64	0.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	8	0	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	2,941	0	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)		5,147	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)		2,941	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1353 | Component CCN: 15-3979 | Period: From 07/17/2023 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/26/2024 1:42 pm

Title XVIII | RHC III | 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)	193,130	193,130	193,130	193,130	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000370	0.000000	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	71	0	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,445	0	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,516	0	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	198,719	198,719	198,719	198,719	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	135,325	135,325	135,325	135,325	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.007629	0.000000	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1,032	0	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	2,548	0	0	0	10.00
11.00	Total number of injections/infusions (from your records)	8	0	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	318.50	0.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	5	0	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)	1,593	0	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)		2,548	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)		1,593	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1353 | Component CCN: 14-8551 | Period: From 07/17/2023 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/26/2024 1:42 pm

Title XVIII | RHC IV | 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)	339,643	339,643	339,643	339,643	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000434	0.000097	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	147	33	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	3,251	161	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	3,398	194	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	345,196	345,196	345,196	345,196	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	252,422	252,422	252,422	252,422	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.009844	0.000562	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2,485	142	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	5,883	336	0	0	10.00
11.00	Total number of injections/infusions (from your records)	18	4	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	326.83	84.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	8	2	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	2,615	168	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)		6,219	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)		2,783	16.00

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

Provider CCN: 14-1353 | Component CCN: 14-3424 | Period: From 07/17/2023 To 09/30/2023 | Worksheet M-5 | Date/Time Prepared: 2/26/2024 1:42 pm

RHC I | Cost

		Part B mm/dd/yyyy 1.00	Part B Amount 2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		33,827	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)		33,827	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		11,326	6.02
7.00	Total Medicare program liability (see instructions)		22,501	7.00

			Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00	
		0			
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101		8.00

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

Provider CCN: 14-1353 | Component CCN: 14-3425 | Period: From 07/17/2023 To 09/30/2023 | Worksheet M-5 | Date/Time Prepared: 2/26/2024 1:42 pm

RHC II | Cost

		Part B mm/dd/yyyy 1.00	Part B Amount 2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		21,783	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)		21,783	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		3,546	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		25,329	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101		8.00

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

Provider CCN: 14-1353 | Component CCN: 15-3979 | Period: From 07/17/2023 To 09/30/2023 | Worksheet M-5 | Date/Time Prepared: 2/26/2024 1:42 pm

RHC III | Cost

		Part B mm/dd/yyyy 1.00	Part B Amount 2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		80,964	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)		80,964	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		10,307	6.02
7.00	Total Medicare program liability (see instructions)		70,657	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101		8.00

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

Provider CCN: 14-1353 | Component CCN: 14-8551 | Period: From 07/17/2023 To 09/30/2023 | Worksheet M-5 | Date/Time Prepared: 2/26/2024 1:42 pm

RHC IV | Cost

		Part B mm/dd/yyyy 1.00	Part B Amount 2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		47,049	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)		47,049	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		15,088	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		62,137	7.00

			Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00	
		0			
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101		8.00