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: 14-1320	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/23/2024 4:01 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/23/2024 Time: 4:01 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 PARIS COMMUNITY HOSPITAL (14-1320) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	444,076	1,146,404	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	102,669	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		335,219		0	10.00
10.01	RURAL HEALTH CLINIC II	0		32,350		0	10.01
10.02	RURAL HEALTH CLINIC III	0		39,346		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		49,443		0	10.03
10.04	RURAL HEALTH CLINIC V	0		7,277		0	10.04
10.05	RURAL HEALTH CLINIC VI	0		0		0	10.05
200.00	TOTAL	0	546,745	1,610,039	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2024 4:01 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 721 EAST COURT STREET	PO Box:			1.00
2.00	City: PARIS	State: IL	Zip Code: 61944-	County: EDGAR	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	PARIS COMMUNITY HOSPITAL	141320	99914	1	06/30/2002	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PARIS COMMUNITY HOSPITAL	14Z320	99914		06/30/2002	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FMC	143987	99914		09/24/1994	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	HATCH	143989	99914		01/01/1995	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	FMC OAKLAND	148596	99914		02/22/2019	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	EZ CARE - PARIS	148607	99914		09/25/2019	N	O	N	15.03
15.04	Hospital-Based Health Clinic - RHC V	EZ CARE MARSHALL	148606	99914		11/14/2019	N	O	N	15.04
15.05	Hospital-Based Health Clinic - RHC VI	SYCAMORE WELLNESS	158573	99914		11/29/2023	N	O	N	15.05
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis	HORIZON HEALTH DIALYSIS CENTER	142341	99914		03/01/2023				18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1320	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/23/2024 4:01 pm

		1.00	2.00	3.00	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2024 4:01 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
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: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2024 4:01 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: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2024 4:01 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: 14-1320	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/23/2024 4:01 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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2024 4:01 pm

					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00
				1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00
		1.00	2.00	3.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00
	Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	513,302	0	0		118.01
			1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N			122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.		Y	N		123.00
	Certified Transplant Center Information					
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2024 4:01 pm

		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.	N	Y	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	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1320	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/23/2024 4:01 pm

		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: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/23/2024 4:01 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	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/12/2024	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)	N		Y	04/12/2024	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: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 5/23/2024 4:01 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	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.	SHAWN	ADAMS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND COMPANY		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923508	SADAMS@BLUEANDCO.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.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2024 4:01 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	9,125	48,192.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	48,192.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	48,192.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits				0.00	0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	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
26.04	RURAL HEALTH CLINIC V	88.04				0	26.04
26.05	RURAL HEALTH CLINIC VI	88.05				0	26.05
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2024 4:01 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,182	9	2,008			1.00
2.00	HMO and other (see instructions)	286	126				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	206	0	277			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	1,105			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,388	9	3,390			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)	1,388	9	3,390	0.00	487.97	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	11,392	0	47,801	0.00	89.13	26.00
26.01	RURAL HEALTH CLINIC II	435	0	3,942	0.00	6.45	26.01
26.02	RURAL HEALTH CLINIC III	455	0	1,940	0.00	3.90	26.02
26.03	RURAL HEALTH CLINIC IV	2,839	0	20,407	0.00	23.08	26.03
26.04	RURAL HEALTH CLINIC V	628	0	6,767	0.00	5.40	26.04
26.05	RURAL HEALTH CLINIC VI	0	0	0	0.00	0.00	26.05
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	615.93	27.00
28.00	Observation Bed Days		19	1,704			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2024 4:01 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	414	3	607	1.00
2.00	HMO and other (see instructions)			66	43		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	414	3	607	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
26.04	RURAL HEALTH CLINIC V	0.00					26.04
26.05	RURAL HEALTH CLINIC VI	0.00					26.05
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-5 | Date/Time Prepared: 5/23/2024 4:01 pm

		Outpatient		Training		Home		
		Regular	High Flux	Hemodialysis	CAPD / CCPD	Hemodialysis	CAPD / CCPD	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Number of patients in program at end of cost reporting period	12	0	0	0	0	0	1.00
2.00	Number of times per week patient receives dialysis	3.00	0.00	0.00	0.00	0.00	0.00	2.00
3.00	Average patient dialysis time including setup	3.50	0.00	0.00	0.00			3.00
4.00	CAPD exchanges per day				0.00		0.00	4.00
5.00	Number of days in year dialysis furnished	156	0					5.00
6.00	Number of stations	8	0	0	0			6.00
7.00	Treatment capacity per day per station	1	0					7.00
8.00	Utilization (see instructions)	60.74	0.00					8.00
9.00	Average times dialyzers re-used	0.00	0.00					9.00
10.00	Percentage of patients re-using dialyzers	0.00	0.00					10.00

		Y/N	
		1.00	
	ESRD PPS		
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no. (see instructions)	N	10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.)	Y	10.02

		Prior to 1/1	After 12/31	
		1.00	2.00	
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)	0	0	10.03
	TRANSPLANT INFORMATION			
11.00	Number of patients on transplant list	0		11.00
12.00	Number of patients transplanted during the cost reporting period	0		12.00
	EPOETIN			
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.			13.00
14.00	Epoetin amount from Worksheet A for Home Dialysis program			14.00
15.00	Number of EPO units furnished relating to the renal dialysis department			15.00
16.00	Number of EPO units furnished relating to the home dialysis department			16.00
	ARANESP			
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.			17.00
18.00	ARANESP amount from Worksheet A for Home Dialysis program			18.00
19.00	Number of ARANESP units furnished relating to the renal dialysis department			19.00
20.00	Number of ARANESP units furnished relating to the home dialysis department			20.00

		MCP	INITIAL METHOD	
		1.00	2.00	
	PHYSICIAN PAYMENT METHOD			
21.00	Enter "X" if method(s) is applicable		X	21.00

		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1.00	2.00	3.00	4.00	5.00	
	ESAs						
22.00	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)		0	0	0	0	22.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-5 | Date/Time Prepared: 5/23/2024 4:01 pm

		CCN	Treatments	
		1.00	2.00	
23.00	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)		0	23.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320
Component CCN: 14-3987

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

Worksheet S-8
Date/Time Prepared: 5/23/2024 4:01 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			727 EAST COURT STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	PARIS		IL	61944	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
9.01						9.01
9.02						9.02
9.03						9.03
9.04						9.04
9.05						9.05
9.06						9.06
9.07						9.07
9.08						9.08
9.09						9.09
9.10						9.10
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.	N	0	13.01

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320
Component CCN: 14-3987

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

Worksheet S-8
Date/Time Prepared:
5/23/2024 4:01 pm

RHC I | Cost

		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		EDGAR				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	08:00	19:00	08:00	19:00	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	19:00	08:00	11:30		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320 | Component CCN: 14-3989 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/23/2024 4:01 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			144 ILLINOIS		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CHRISMAN		IL	61924	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
9.01						9.01
9.02						9.02
9.03						9.03
9.04						9.04
9.05						9.05
9.06						9.06
9.07						9.07
9.08						9.08
9.09						9.09
9.10						9.10
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	12:00	13:30	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.	N	0	13.01

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320
Component CCN: 14-3989

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

Worksheet S-8
Date/Time Prepared:
5/23/2024 4:01 pm

RHC II | Cost

		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		EDGAR				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	19:30			08:00	12:00	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	12:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320 | Component CCN: 14-8596 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/23/2024 4:01 pm

RHC III | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			721 EAST COURT ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	PARIS		IL	61944	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			08:00	17:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.				N	0	13.01
				Provider name		CCN
				1.00		2.00	
14.00	RHC/FQHC name, CCN						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320
Component CCN: 14-8596

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

Worksheet S-8

Date/Time Prepared:
5/23/2024 4:01 pm

RHC III | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		EDGAR				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	08:00	19:00	08:00	19:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	19:00	08:00	11:30		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320 | Component CCN: 14-8607 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/23/2024 4:01 pm

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1 PHILLIPS LANE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	PARIS		IL	61944	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			08:00	17:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.				N	0	13.01
				Provider name		CCN	
				1.00		2.00	
14.00	RHC/FQHC name, CCN						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1320 | Component CCN: 14-8607 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/23/2024 4:01 pm

RHC IV | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		EDGAR				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	08:00	19:00	08:00	19:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	19:00	08:00	11:30		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320 | Component CCN: 14-8606 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/23/2024 4:01 pm

RHC V | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			1602 NORTH IL HWY 1		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MARSHALL		IL	62441	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			08:00	17:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.				N	0	13.01
				Provider name		CCN
				1.00		2.00	
14.00	RHC/FQHC name, CCN						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320
Component CCN: 14-8606

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

Worksheet S-8
Date/Time Prepared:
5/23/2024 4:01 pm

RHC V | Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		CLARK				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	08:00	19:00	08:00	19:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	19:00	08:00	11:30		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320 | Component CCN: 15-8573 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/23/2024 4:01 pm

RHC VI | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			567 N ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	TERRE HAUTE		IN	47809	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	16:30	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?					12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
13.01	If line 13, column 1, is "Y", are you reporting multiple consolidated RHCs (as defined in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" for yes or "N" for no. If yes, enter in column 2 the number of consolidated RHC groupings and complete a separate Worksheet S-8 for each consolidated RHC grouping. Consolidated RHC groupings are comprised exclusively of grandfathered consolidated RHCs in the grouping or comprised exclusively of new consolidated RHCs in the grouping.			N	0	13.01

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1320
Component CCN: 15-8573

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

Worksheet S-8

Date/Time Prepared:
5/23/2024 4:01 pm

RHC VI | Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1320	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/23/2024 4:01 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)	0.523993	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	13,171,847	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	51,215,596	6.00
7.00	Medicaid cost (line 1 times line 6)	26,836,614	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	13,664,767	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)	13,664,767	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)	1,710,817	0	1,710,817	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	896,456	0	896,456	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)	896,456	0	896,456	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)	5,243,426	26.00
27.00	Medicare reimbursable bad debts (see instructions)	269,816	27.00
27.01	Medicare allowable bad debts (see instructions)	415,100	27.01
28.00	Non-Medicare bad debt amount (see instructions)	4,828,326	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	2,675,293	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	3,571,749	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	17,236,516	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1320	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/23/2024 4:01 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: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/23/2024 4:01 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	NEW CAP REL COSTS-BLDG & FIXT		3,493,913	3,493,913	328,477	3,822,390	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2,300,328	2,300,328	361,092	2,661,420	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	466,056	10,156,697	10,622,753	173,101	10,795,854	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	5,986,416	9,113,122	15,099,538	-561,431	14,538,107	5.01
5.02	00560	ADMITTING	2,081,253	3,474,613	5,555,866	-630	5,555,236	5.02
7.00	00700	OPERATION OF PLANT	1,249,995	1,712,810	2,962,805	-3,999	2,958,806	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	134,520	134,520	0	134,520	8.00
9.00	00900	HOUSEKEEPING	1,098,044	481,149	1,579,193	0	1,579,193	9.00
10.00	01000	DIETARY	852,758	827,580	1,680,338	-1,163,493	516,845	10.00
11.00	01100	CAFETERIA	0	0	0	1,162,893	1,162,893	11.00
13.00	01300	NURSING ADMINISTRATION	350,255	74,846	425,101	0	425,101	13.00
15.00	01500	PHARMACY	395,181	4,939,698	5,334,879	-4,764,189	570,690	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	692,160	191,982	884,142	0	884,142	16.00
17.00	01700	SOCIAL SERVICE	0	702	702	0	702	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,731,071	1,143,239	5,874,310	-47,201	5,827,109	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,109,816	8,084,387	11,194,203	-11,143,928	50,275	50.00
53.00	05300	ANESTHESIOLOGY	2,154,351	669,898	2,824,249	-222,609	2,601,640	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,549,839	2,346,357	4,896,196	-211,147	4,685,049	54.00
60.00	06000	LABORATORY	1,079,793	2,840,630	3,920,423	-1,000,716	2,919,707	60.00
65.00	06500	RESPIRATORY THERAPY	700,412	241,712	942,124	-59,356	882,768	65.00
66.00	06600	PHYSICAL THERAPY	1,440,249	337,611	1,777,860	-3,594	1,774,266	66.00
69.00	06900	ELECTROCARDIOLOGY	0	95,571	95,571	108,457	204,028	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	39,041	39,041	8,291,730	8,330,771	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	4,425,188	4,425,188	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,066,890	5,066,890	73.00
74.00	07400	RENAL DIALYSIS	544,301	443,646	987,947	-45,998	941,949	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,228,615	4,785,695	15,014,310	0	15,014,310	88.00
88.01	08801	RURAL HEALTH CLINIC II	509,096	181,599	690,695	0	690,695	88.01
88.02	08802	RURAL HEALTH CLINIC III	633,376	147,851	781,227	0	781,227	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,284,280	948,708	3,232,988	0	3,232,988	88.03
88.04	08804	RURAL HEALTH CLINIC V	504,126	171,923	676,049	0	676,049	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	1,423	1,423	0	1,423	88.05
90.00	09000	CLINIC	1,002,751	212,603	1,215,354	-35,206	1,180,148	90.00
90.01	04951	CHEMO/PAIN	2,663,946	1,602,824	4,266,770	-553,387	3,713,383	90.01
90.02	09002	SENIOR CARE	98,094	611,476	709,570	-1,352	708,218	90.02
90.03	09003	SLEEP LAB	0	0	0	0	0	90.03
90.04	09001	ORTHOPEDICS	1,444,228	316,176	1,760,404	-4,803	1,755,601	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	90	90	0	90	90.05
91.00	09100	EMERGENCY	2,574,090	2,556,306	5,130,396	-62,859	5,067,537	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,590,623	436,647	2,027,270	-8,841	2,018,429	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	34,400	34,400	-23,089	11,311	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,015,175	65,151,773	118,166,948	0	118,166,948	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,553,207	5,114,620	7,667,827	0	7,667,827	192.00
192.01	19202	HOME HEALTHCARE SVC	512,612	104,122	616,734	0	616,734	192.01
192.02	19201	NAL CLINIC	435,603	148,160	583,763	0	583,763	192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	56,516,597	70,518,675	127,035,272	0	127,035,272	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/23/2024 4:01 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-63,771	3,758,619		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	2,661,420		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-297,637	10,498,217		4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	-2,993,345	11,544,762		5.01
5.02	00560	ADMITTING	-201	5,555,035		5.02
7.00	00700	OPERATION OF PLANT	-5,783	2,953,023		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	134,520		8.00
9.00	00900	HOUSEKEEPING	-33	1,579,160		9.00
10.00	01000	DIETARY	-34,775	482,070		10.00
11.00	01100	CAFETERIA	-187,198	975,695		11.00
13.00	01300	NURSING ADMINISTRATION	0	425,101		13.00
15.00	01500	PHARMACY	-64,654	506,036		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,788	880,354		16.00
17.00	01700	SOCIAL SERVICE	0	702		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-866,151	4,960,958		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-4,969	45,306		50.00
53.00	05300	ANESTHESIOLOGY	-1,905,144	696,496		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-760,830	3,924,219		54.00
60.00	06000	LABORATORY	-212	2,919,495		60.00
65.00	06500	RESPIRATORY THERAPY	-6	882,762		65.00
66.00	06600	PHYSICAL THERAPY	-43,113	1,731,153		66.00
69.00	06900	ELECTROCARDIOLOGY	-74,577	129,451		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,330,771		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,425,188		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,066,890		73.00
74.00	07400	RENAL DIALYSIS	-483	941,466		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-265,078	14,749,232		88.00
88.01	08801	RURAL HEALTH CLINIC II	-734	689,961		88.01
88.02	08802	RURAL HEALTH CLINIC III	-3,197	778,030		88.02
88.03	08803	RURAL HEALTH CLINIC IV	-349	3,232,639		88.03
88.04	08804	RURAL HEALTH CLINIC V	-1,563	674,486		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	1,423		88.05
90.00	09000	CLINIC	-644,574	535,574		90.00
90.01	04951	CHEMO/PAIN	-765,436	2,947,947		90.01
90.02	09002	SENIOR CARE	-3,028	705,190		90.02
90.03	09003	SLEEP LAB	0	0		90.03
90.04	09001	ORTHOPEDICS	-1,411,154	344,447		90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	-750	-660		90.05
91.00	09100	EMERGENCY	-853,172	4,214,365		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-20,140	1,998,289		95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	11,311		96.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,275,845	106,891,103		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,667,827		192.00
192.01	19202	HOME HEALTHCARE SVC	0	616,734		192.01
192.02	19201	NAL CLINIC	0	583,763		192.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,275,845	115,759,427		200.00

RECLASSIFICATIONS | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/23/2024 4:01 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RENTAL EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	361,092		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
	0		0	361,092		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	533,392	629,501		1.00
	0		533,392	629,501		
	C - EKG					
1.00	ELECTROCARDIOLOGY	69.00	73,497	0		1.00
2.00		0.00	0	0		2.00
	0		73,497	0		
	D - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	328,477		1.00
	0		0	328,477		
	E - PATIENT SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	8,305,709		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	48		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
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
	0		0	8,305,757		
	F - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,066,890		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
15.00		0.00	0	0		15.00
	0		0	5,066,890		
	H - BENEFITS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	174,020		1.00
	TOTALS		0	174,020		
	I - STRESS TEST					
1.00	ELECTROCARDIOLOGY	69.00	27,705	7,279		1.00
	0		27,705	7,279		

RECLASSIFICATIONS | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/23/2024 4:01 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	J - IMPLANT EXPENSE				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	4,425,188	1.00
	0		0	4,425,188	
500.00	Grand Total: Increases		634,594	19,298,204	500.00

RECLASSIFICATIONS | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/23/2024 4:01 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENTAL EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	910	10		1.00
2.00	ADMINISTRATIVE AND GENERAL	5.01	0	15,806	0		2.00
3.00	ADMITTING	5.02	0	630	0		3.00
4.00	OPERATION OF PLANT	7.00	0	3,999	0		4.00
5.00	DIETARY	10.00	0	336	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	3,026	0		6.00
7.00	OPERATING ROOM	50.00	0	317,373	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	2,459	0		8.00
9.00	LABORATORY	60.00	0	152	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	666	0		10.00
11.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	13,979	0		11.00
12.00	CHEMO/PAIN	90.01	0	109	0		12.00
13.00	SENIOR CARE	90.02	0	1,352	0		13.00
14.00	AMBULANCE SERVICES	95.00	0	295	0		14.00
	0		0	361,092			
	B - CAFETERIA						
1.00	DIETARY	10.00	533,392	629,501	0		1.00
	0		533,392	629,501			
	C - EKG						
1.00	ADULTS & PEDIATRICS	30.00	18,980	0	0		1.00
2.00	RESPIRATORY THERAPY	65.00	54,517	0	0		2.00
	0		73,497	0			
	D - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	328,477	12		1.00
	0		0	328,477			
	E - PATIENT SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9	0		1.00
2.00	ADMINISTRATIVE AND GENERAL	5.01	0	42,708	0		2.00
3.00	DIETARY	10.00	0	253	0		3.00
4.00	PHARMACY	15.00	0	40,250	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	24,827	0		5.00
6.00	OPERATING ROOM	50.00	0	6,398,831	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	121,738	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	194,477	0		8.00
9.00	LABORATORY	60.00	0	1,000,564	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	4,146	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	3,330	0		11.00
12.00	RENAL DIALYSIS	74.00	0	44,961	0		12.00
13.00	CLINIC	90.00	0	130	0		13.00
14.00	CHEMO/PAIN	90.01	0	336,641	0		14.00
15.00	ORTHOPEDICS	90.04	0	4,803	0		15.00
16.00	EMERGENCY	91.00	0	60,630	0		16.00
17.00	AMBULANCE SERVICES	95.00	0	4,370	0		17.00
18.00	DURABLE MEDICAL EQUIP. - RENTED	96.00	0	23,089	0		18.00
	0		0	8,305,757			
	F - DRUGS						
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	420	0		1.00
2.00	DIETARY	10.00	0	11	0		2.00
3.00	PHARMACY	15.00	0	4,723,939	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	368	0		4.00
5.00	OPERATING ROOM	50.00	0	2,536	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	98,412	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	16,670	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	27	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	264	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	0	72	0		10.00
11.00	RENAL DIALYSIS	74.00	0	1,037	0		11.00
12.00	CLINIC	90.00	0	92	0		12.00
13.00	CHEMO/PAIN	90.01	0	216,637	0		13.00
14.00	EMERGENCY	91.00	0	2,229	0		14.00
15.00	AMBULANCE SERVICES	95.00	0	4,176	0		15.00
	0		0	5,066,890			
	H - BENEFITS RECLASS						
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	174,020	0		1.00
	TOTALS		0	174,020			
	I - STRESS TEST						
1.00	CLINIC	90.00	27,705	7,279	0		1.00
	0		27,705	7,279			

RECLASSIFICATIONS | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/23/2024 4:01 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	J - IMPLANT EXPENSE						
1.00	OPERATING ROOM	50.00	0	4,425,188	0		1.00
	0		0	4,425,188			
500.00	Grand Total: Decreases		634,594	19,298,204			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/23/2024 4:01 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	1,626,832	0	0	0	0	1.00
2.00	Land Improvements	3,656,398	637,283	0	637,283	0	2.00
3.00	Buildings and Fixtures	68,149,938	5,050,600	0	5,050,600	0	3.00
4.00	Building Improvements	6,204,716	1,427,876	0	1,427,876	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	26,475,688	2,635,561	0	2,635,561	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	106,113,572	9,751,320	0	9,751,320	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	106,113,572	9,751,320	0	9,751,320	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,626,832	0	1.00
2.00	Land Improvements	4,293,681	0	2.00
3.00	Buildings and Fixtures	73,200,538	0	3.00
4.00	Building Improvements	7,632,592	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	29,111,249	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	115,864,892	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	115,864,892	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/23/2024 4:01 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	NEW CAP REL COSTS-BLDG & FIXT	2,282,464	0	1,211,449	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,300,328	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,582,792	0	1,211,449	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	NEW CAP REL COSTS-BLDG & FIXT	0	3,493,913	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,300,328	2.00
3.00	Total (sum of lines 1-2)	0	5,794,241	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 5/23/2024 4:01 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	86,753,643	0	86,753,643	0.748748	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	29,111,249	0	29,111,249	0.251252	0	2.00
3.00	Total (sum of lines 1-2)	115,864,892	0	115,864,892	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,218,693	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,300,328	361,092	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,519,021	361,092	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	NEW CAP REL COSTS-BLDG & FIXT	1,211,449	328,477	0	0	3,758,619	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,661,420	2.00
3.00	Total (sum of lines 1-2)	1,211,449	328,477	0	0	6,420,039	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/23/2024 4:01 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-63,771	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW 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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,140,784			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	-187,198	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-3,788	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW 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

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/23/2024 4:01 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	NONALLOWABLE EXPENSES	A	-640	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
34.00	NONALLOWABLE EXPENSES	A	-247,466	ADMINISTRATIVE AND GENERAL	5.01	0	34.00
34.01	NONALLOWABLE EXPENSES	A	-99	ADMITTING	5.02	0	34.01
34.02	NONALLOWABLE EXPENSES	A	-137	OPERATING ROOM	50.00	0	34.02
34.03	NONALLOWABLE EXPENSES	A	-339	RADIOLOGY-DIAGNOSTIC	54.00	0	34.03
34.04	NONALLOWABLE EXPENSES	A	-147	RENAL DIALYSIS	74.00	0	34.04
34.05	NONALLOWABLE EXPENSES	A	-172,866	RURAL HEALTH CLINIC	88.00	0	34.05
34.06	NONALLOWABLE EXPENSES	A	-694	RURAL HEALTH CLINIC II	88.01	0	34.06
34.07	NONALLOWABLE EXPENSES	A	-3,181	RURAL HEALTH CLINIC III	88.02	0	34.07
34.08	NONALLOWABLE EXPENSES	A	-273	RURAL HEALTH CLINIC IV	88.03	0	34.08
34.09	NONALLOWABLE EXPENSES	A	-1,563	RURAL HEALTH CLINIC V	88.04	0	34.09
34.10	NONALLOWABLE EXPENSES	A	-357	CHEMO/PAIN	90.01	0	34.10
34.11	NONALLOWABLE EXPENSES	A	-3,021	SENIOR CARE	90.02	0	34.11
34.12	NONALLOWABLE EXPENSES	A	-10	ORTHOPEDICS	90.04	0	34.12
35.00	NONALLOWABLE EXPENSES	A	-2,083	AMBULANCE SERVICES	95.00	0	35.00
35.01	ANESTHESIA SALARIES	A	-1,133,551	ANESTHESIOLOGY	53.00	0	35.01
35.02	ANESTHESIA BENEFITS	A	-296,580	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.02
36.00	OTHER INCOME	B	-417	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.00
36.01	OTHER INCOME	B	-656,294	ADMINISTRATIVE AND GENERAL	5.01	0	36.01
37.00	OTHER INCOME	B	-102	ADMITTING	5.02	0	37.00
37.01	OTHER INCOME	B	-5,783	OPERATION OF PLANT	7.00	0	37.01
37.02	OTHER INCOME	B	-33	HOUSEKEEPING	9.00	0	37.02
37.03	OTHER INCOME	B	-34,775	DIETARY	10.00	0	37.03
37.04	OTHER INCOME	B	-64,654	PHARMACY	15.00	0	37.04
37.05	OTHER INCOME	B	-27	ADULTS & PEDIATRICS	30.00	0	37.05
37.06	OTHER INCOME	B	-2,503	OPERATING ROOM	50.00	0	37.06
37.07	OTHER INCOME	B	-56	ANESTHESIOLOGY	53.00	0	37.07
37.08	OTHER INCOME	B	-1,516	RADIOLOGY-DIAGNOSTIC	54.00	0	37.08
37.09	OTHER INCOME	B	-212	LABORATORY	60.00	0	37.09
37.10	OTHER INCOME	B	-6	RESPIRATORY THERAPY	65.00	0	37.10
37.11	OTHER INCOME	B	-43,113	PHYSICAL THERAPY	66.00	0	37.11
37.12	OTHER INCOME	B	-336	RENAL DIALYSIS	74.00	0	37.12
37.13	OTHER INCOME	B	-92,212	RURAL HEALTH CLINIC	88.00	0	37.13
37.14	OTHER INCOME	B	-40	RURAL HEALTH CLINIC II	88.01	0	37.14
37.15	OTHER INCOME	B	-16	RURAL HEALTH CLINIC III	88.02	0	37.15
37.16	OTHER INCOME	B	-76	RURAL HEALTH CLINIC IV	88.03	0	37.16
37.17	OTHER INCOME	B	-4,671	CLINIC	90.00	0	37.17
37.18	OTHER INCOME	B	-2,021	CHEMO/PAIN	90.01	0	37.18
37.19	OTHER INCOME	B	-7	SENIOR CARE	90.02	0	37.19
37.20	OTHER INCOME	B	-750	BEHAVIORAL HEALTH CLINIC	90.05	0	37.20
37.21	OTHER INCOME	B	-35	EMERGENCY	91.00	0	37.21
37.22	OTHER INCOME	B	-18,057	AMBULANCE SERVICES	95.00	0	37.22
37.23	LOBBYING DUES	A	-18,466	ADMINISTRATIVE AND GENERAL	5.01	0	37.23
37.24	MEDICAID ASSESSMENT FEES	A	-2,071,119	ADMINISTRATIVE AND GENERAL	5.01	0	37.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,275,845				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: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/23/2024 4:01 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	916,124	866,124	50,000	0	0	1.00
2.00	50.00	OPERATING ROOM	2,329	2,329	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	821,537	771,537	50,000	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	758,975	758,975	0	0	0	4.00
5.00	60.00	LABORATORY	70,000	0	70,000	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	24,554	0	24,554	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	86,577	74,577	12,000	0	0	7.00
8.00	74.00	RENAL DIALYSIS	120,000	0	120,000	0	0	8.00
9.00	90.00	CLINIC	689,903	639,903	50,000	0	0	9.00
10.00	90.01	CHEMO/PAIN	820,289	763,058	57,231	0	0	10.00
11.00	90.02	SENIOR CARE	33,150	0	33,150	0	0	11.00
12.00	90.04	ORTHOPEDICS	1,411,144	1,411,144	0	0	0	12.00
13.00	91.00	EMERGENCY	2,753,137	853,137	1,900,000	0	0	13.00
200.00			8,507,719	6,140,784	2,366,935		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	74.00	RENAL DIALYSIS	0	0	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	90.01	CHEMO/PAIN	0	0	0	0	0	10.00
11.00	90.02	SENIOR CARE	0	0	0	0	0	11.00
12.00	90.04	ORTHOPEDICS	0	0	0	0	0	12.00
13.00	91.00	EMERGENCY	0	0	0	0	0	13.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	866,124		1.00
2.00	50.00	OPERATING ROOM	0	0	0	2,329		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	771,537		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	758,975		4.00
5.00	60.00	LABORATORY	0	0	0	0		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	74,577		7.00
8.00	74.00	RENAL DIALYSIS	0	0	0	0		8.00
9.00	90.00	CLINIC	0	0	0	639,903		9.00
10.00	90.01	CHEMO/PAIN	0	0	0	763,058		10.00
11.00	90.02	SENIOR CARE	0	0	0	0		11.00
12.00	90.04	ORTHOPEDICS	0	0	0	1,411,144		12.00
13.00	91.00	EMERGENCY	0	0	0	853,137		13.00
200.00			0	0	0	6,140,784		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/23/2024 4:01 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	3,758,619	3,758,619				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2,661,420		2,661,420			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,498,217	25,625	18,145	10,541,987		4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	11,544,762	564,838	399,953	1,693,923	14,203,476	5.01
5.02	00560	ADMITTING	5,555,035	90,947	64,398	588,911	6,299,291	5.02
7.00	00700	OPERATION OF PLANT	2,953,023	327,878	232,166	353,699	3,866,766	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	134,520	26,842	19,006	0	180,368	8.00
9.00	00900	HOUSEKEEPING	1,579,160	18,880	13,369	310,703	1,922,112	9.00
10.00	01000	DIETARY	482,070	84,810	60,053	90,368	717,301	10.00
11.00	01100	CAFETERIA	975,695	38,590	27,325	150,929	1,192,539	11.00
13.00	01300	NURSING ADMINISTRATION	425,101	38,148	27,012	99,108	589,369	13.00
15.00	01500	PHARMACY	506,036	24,077	17,049	111,820	658,982	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	880,354	61,672	43,669	195,854	1,181,549	16.00
17.00	01700	SOCIAL SERVICE	702	4,312	3,054	0	8,068	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,960,958	387,174	274,152	1,333,333	6,955,617	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,306	388,970	275,424	879,954	1,589,654	50.00
53.00	05300	ANESTHESIOLOGY	696,496	3,290	2,329	288,846	990,961	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,924,219	203,594	144,162	721,502	4,993,477	54.00
60.00	06000	LABORATORY	2,919,495	84,838	60,072	305,538	3,369,943	60.00
65.00	06500	RESPIRATORY THERAPY	882,762	10,532	7,458	182,762	1,083,514	65.00
66.00	06600	PHYSICAL THERAPY	1,731,153	647,051	458,162	407,533	3,243,899	66.00
69.00	06900	ELECTROCARDIOLOGY	129,451	14,485	10,257	28,636	182,829	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,330,771	0	0	0	8,330,771	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,425,188	0	0	0	4,425,188	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,066,890	0	0	0	5,066,890	73.00
74.00	07400	RENAL DIALYSIS	941,466	0	0	154,015	1,095,481	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,749,232	0	0	0	14,749,232	88.00
88.01	08801	RURAL HEALTH CLINIC II	689,961	41,465	29,361	0	760,787	88.01
88.02	08802	RURAL HEALTH CLINIC III	778,030	0	0	0	778,030	88.02
88.03	08803	RURAL HEALTH CLINIC IV	3,232,639	301,396	213,414	0	3,747,449	88.03
88.04	08804	RURAL HEALTH CLINIC V	674,486	43,981	31,142	0	749,609	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1,423	0	0	0	1,423	88.05
90.00	09000	CLINIC	535,574	17,001	12,038	275,899	840,512	90.00
90.01	04951	CHEMO/PAIN	2,947,947	42,681	30,222	753,790	3,774,640	90.01
90.02	09002	SENIOR CARE	705,190	0	0	27,757	732,947	90.02
90.03	09003	SLEEP LAB	0	0	0	0	0	90.03
90.04	09001	ORTHOPEDICS	344,447	50,947	36,075	408,659	840,128	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	-660	11,831	8,378	0	19,549	90.05
91.00	09100	EMERGENCY	4,214,365	142,474	100,884	728,365	5,186,088	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,998,289	0	0	450,083	2,448,372	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	11,311	0	0	0	11,311	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	106,891,103	3,698,329	2,618,729	10,541,987	106,788,122	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,667,827	0	0	0	7,667,827	192.00
192.01	19202	HOME HEALTHCARE SVC	616,734	0	0	0	616,734	192.01
192.02	19201	NAL CLINIC	583,763	60,290	42,691	0	686,744	192.02
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)	115,759,427	3,758,619	2,661,420	10,541,987	115,759,427	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/23/2024 4:01 pm

		Cost Center Description	ADMINISTRATIVE AND GENERAL	ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	14,203,476					5.01
5.02	00560	ADMITTING	881,013	7,180,304				5.02
7.00	00700	OPERATION OF PLANT	540,802	0	4,407,568			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,226	0	51,202	256,796		8.00
9.00	00900	HOUSEKEEPING	268,825	0	36,015	0	2,226,952	9.00
10.00	01000	DIETARY	100,321	0	161,779	0	79,506	10.00
11.00	01100	CAFETERIA	166,787	0	73,612	0	36,177	11.00
13.00	01300	NURSING ADMINISTRATION	82,429	0	72,769	0	35,762	13.00
15.00	01500	PHARMACY	92,165	0	45,929	0	22,572	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	165,250	0	117,643	0	57,816	16.00
17.00	01700	SOCIAL SERVICE	1,128	0	8,226	0	4,043	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	972,806	1,160,274	738,549	256,796	362,961	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	222,327	269,683	741,977	0	364,645	50.00
53.00	05300	ANESTHESIOLOGY	138,595	0	6,275	0	3,084	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	698,383	740,008	388,363	0	190,862	54.00
60.00	06000	LABORATORY	471,317	562,589	161,831	0	79,532	60.00
65.00	06500	RESPIRATORY THERAPY	151,539	215,016	20,090	0	9,873	65.00
66.00	06600	PHYSICAL THERAPY	453,688	528,267	1,234,274	0	606,585	66.00
69.00	06900	ELECTROCARDIOLOGY	25,570	26,226	27,631	0	13,579	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,165,133	1,086,950	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	618,902	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	708,650	855,649	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	153,213	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,062,777	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	106,403	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	108,814	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	524,114	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	104,840	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	199	0	0	0	0	88.05
90.00	09000	CLINIC	117,553	152,498	0	0	15,938	90.00
90.01	04951	CHEMO/PAIN	527,917	431,479	0	0	40,012	90.01
90.02	09002	SENIOR CARE	102,509	129,963	0	0	0	90.02
90.03	09003	SLEEP LAB	0	0	0	0	0	90.03
90.04	09001	ORTHOPEDICS	117,499	128,464	0	0	47,761	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	2,734	32,604	22,569	0	11,091	90.05
91.00	09100	EMERGENCY	725,321	860,634	271,775	0	133,564	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	342,427	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	1,582	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,948,758	7,180,304	4,180,509	256,796	2,115,363	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,072,415	0	112,053	0	55,069	192.00
192.01	19202	HOME HEALTHCARE SVC	86,256	0	0	0	0	192.01
192.02	19201	NAL CLINIC	96,047	0	115,006	0	56,520	192.02
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)	14,203,476	7,180,304	4,407,568	256,796	2,226,952	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/23/2024 4:01 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
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	1,058,907					10.00
11.00	01100	CAFETERIA	0	1,469,115				11.00
13.00	01300	NURSING ADMINISTRATION	0	19,800	800,129			13.00
15.00	01500	PHARMACY	0	22,340	0	841,988		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	39,128	0	0	1,561,386	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,058,907	266,388	264,799	0	44,241	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	175,801	172,165	0	268,739	50.00
53.00	05300	ANESTHESIOLOGY	0	57,707	0	0	38,774	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	144,145	0	0	375,814	54.00
60.00	06000	LABORATORY	0	61,042	0	0	227,792	60.00
65.00	06500	RESPIRATORY THERAPY	0	36,513	0	0	11,128	65.00
66.00	06600	PHYSICAL THERAPY	0	81,419	0	0	97,521	66.00
69.00	06900	ELECTROCARDIOLOGY	0	5,721	0	0	26,602	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	89,032	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	66,171	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	841,988	161,104	73.00
74.00	07400	RENAL DIALYSIS	0	30,770	24,506	0	11,615	74.00
		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
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	55,120	0	0	11,250	90.00
90.01	04951	CHEMO/PAIN	0	150,596	125,236	0	36,912	90.01
90.02	09002	SENIOR CARE	0	5,545	6,141	0	4,604	90.02
90.03	09003	SLEEP LAB	0	0	0	0	0	90.03
90.04	09001	ORTHOPEDICS	0	81,644	0	0	7,005	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	0	0	0	3	90.05
91.00	09100	EMERGENCY	0	145,516	106,147	0	83,079	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	89,920	95,866	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,058,907	1,469,115	794,860	841,988	1,561,386	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	5,269	0	0	192.00
192.01	19202	HOME HEALTHCARE SVC	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	0	0	0	0	192.02
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)	1,058,907	1,469,115	800,129	841,988	1,561,386	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/23/2024 4:01 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
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
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	21,465					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,465	12,102,803	0	12,102,803		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,804,991	0	3,804,991		50.00
53.00	05300	ANESTHESIOLOGY	0	1,235,396	0	1,235,396		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,531,052	0	7,531,052		54.00
60.00	06000	LABORATORY	0	4,934,046	0	4,934,046		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,527,673	0	1,527,673		65.00
66.00	06600	PHYSICAL THERAPY	0	6,245,653	0	6,245,653		66.00
69.00	06900	ELECTROCARDIOLOGY	0	308,158	0	308,158		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,671,886	0	10,671,886		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,110,261	0	5,110,261		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,634,281	0	7,634,281		73.00
74.00	07400	RENAL DIALYSIS	0	1,315,585	0	1,315,585		74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	16,812,009	0	16,812,009		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	867,190	0	867,190		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	886,844	0	886,844		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	4,271,563	0	4,271,563		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	854,449	0	854,449		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	1,622	0	1,622		88.05
90.00	09000	CLINIC	0	1,192,871	0	1,192,871		90.00
90.01	04951	CHEMO/PAIN	0	5,086,792	0	5,086,792		90.01
90.02	09002	SENIOR CARE	0	981,709	0	981,709		90.02
90.03	09003	SLEEP LAB	0	0	0	0		90.03
90.04	09001	ORTHOPEDICS	0	1,222,501	0	1,222,501		90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	88,550	0	88,550		90.05
91.00	09100	EMERGENCY	0	7,512,124	0	7,512,124		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,976,585	0	2,976,585		95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	12,893	0	12,893		96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,465	105,189,487	0	105,189,487		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,912,633	0	8,912,633		192.00
192.01	19202	HOME HEALTHCARE SVC	0	702,990	0	702,990		192.01
192.02	19201	NAL CLINIC	0	954,317	0	954,317		192.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	21,465	115,759,427	0	115,759,427		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/23/2024 4:01 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	25,625	18,145	43,770	43,770	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	0	564,838	399,953	964,791	7,028	5.01
5.02	00560	ADMITTING	0	90,947	64,398	155,345	2,445	5.02
7.00	00700	OPERATION OF PLANT	0	327,878	232,166	560,044	1,469	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,842	19,006	45,848	0	8.00
9.00	00900	HOUSEKEEPING	0	18,880	13,369	32,249	1,290	9.00
10.00	01000	DIETARY	0	84,810	60,053	144,863	375	10.00
11.00	01100	CAFETERIA	0	38,590	27,325	65,915	627	11.00
13.00	01300	NURSING ADMINISTRATION	0	38,148	27,012	65,160	412	13.00
15.00	01500	PHARMACY	0	24,077	17,049	41,126	464	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	61,672	43,669	105,341	813	16.00
17.00	01700	SOCIAL SERVICE	0	4,312	3,054	7,366	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	387,174	274,152	661,326	5,537	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	388,970	275,424	664,394	3,654	50.00
53.00	05300	ANESTHESIOLOGY	0	3,290	2,329	5,619	1,199	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	203,594	144,162	347,756	2,996	54.00
60.00	06000	LABORATORY	0	84,838	60,072	144,910	1,269	60.00
65.00	06500	RESPIRATORY THERAPY	0	10,532	7,458	17,990	759	65.00
66.00	06600	PHYSICAL THERAPY	0	647,051	458,162	1,105,213	1,692	66.00
69.00	06900	ELECTROCARDIOLOGY	0	14,485	10,257	24,742	119	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	640	74.00
		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	41,465	29,361	70,826	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	301,396	213,414	514,810	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	43,981	31,142	75,123	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	17,001	12,038	29,039	1,146	90.00
90.01	04951	CHEMO/PAIN	0	42,681	30,222	72,903	3,130	90.01
90.02	09002	SENIOR CARE	0	0	0	0	115	90.02
90.03	09003	SLEEP LAB	0	0	0	0	0	90.03
90.04	09001	ORTHOPEDICS	0	50,947	36,075	87,022	1,697	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	11,831	8,378	20,209	0	90.05
91.00	09100	EMERGENCY	0	142,474	100,884	243,358	3,025	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	1,869	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,698,329	2,618,729	6,317,058	43,770	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19202	HOME HEALTHCARE SVC	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	60,290	42,691	102,981	0	192.02
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	3,758,619	2,661,420	6,420,039	43,770	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/23/2024 4:01 pm

		Cost Center Description	ADMINISTRATIVE AND GENERAL	ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	971,819					5.01
5.02	00560	ADMITTING	60,278	218,068				5.02
7.00	00700	OPERATION OF PLANT	37,001	0	598,514			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,726	0	6,953	54,527		8.00
9.00	00900	HOUSEKEEPING	18,393	0	4,891	0	56,823	9.00
10.00	01000	DIETARY	6,864	0	21,968	0	2,029	10.00
11.00	01100	CAFETERIA	11,411	0	9,996	0	923	11.00
13.00	01300	NURSING ADMINISTRATION	5,640	0	9,881	0	913	13.00
15.00	01500	PHARMACY	6,306	0	6,237	0	576	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,306	0	15,975	0	1,475	16.00
17.00	01700	SOCIAL SERVICE	77	0	1,117	0	103	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	66,558	35,225	100,289	54,527	9,261	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,211	8,191	100,755	0	9,304	50.00
53.00	05300	ANESTHESIOLOGY	9,483	0	852	0	79	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,783	22,476	52,737	0	4,870	54.00
60.00	06000	LABORATORY	32,247	17,087	21,975	0	2,029	60.00
65.00	06500	RESPIRATORY THERAPY	10,368	6,531	2,728	0	252	65.00
66.00	06600	PHYSICAL THERAPY	31,041	16,045	167,605	0	15,478	66.00
69.00	06900	ELECTROCARDIOLOGY	1,749	797	3,752	0	346	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	79,717	33,013	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	42,345	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,485	25,988	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	10,483	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	141,165	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,280	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	7,445	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	35,859	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	7,173	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	14	0	0	0	0	88.05
90.00	09000	CLINIC	8,043	4,632	0	0	407	90.00
90.01	04951	CHEMO/PAIN	36,120	13,105	0	0	1,021	90.01
90.02	09002	SENIOR CARE	7,014	3,947	0	0	0	90.02
90.03	09003	SLEEP LAB	0	0	0	0	0	90.03
90.04	09001	ORTHOPEDICS	8,039	3,902	0	0	1,219	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	187	990	3,065	0	283	90.05
91.00	09100	EMERGENCY	49,626	26,139	36,905	0	3,408	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	23,428	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	108	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	885,973	218,068	567,681	54,527	53,976	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	73,373	0	15,216	0	1,405	192.00
192.01	19202	HOME HEALTHCARE SVC	5,902	0	0	0	0	192.01
192.02	19201	NAL CLINIC	6,571	0	15,617	0	1,442	192.02
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)	971,819	218,068	598,514	54,527	56,823	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/23/2024 4:01 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
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	176,099					10.00
11.00	01100	CAFETERIA	0	88,872				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,198	83,204			13.00
15.00	01500	PHARMACY	0	1,352	0	56,061		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,367	0	0	137,277	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	176,099	16,109	27,536	0	3,889	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	10,636	17,903	0	23,622	50.00
53.00	05300	ANESTHESIOLOGY	0	3,491	0	0	3,408	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,720	0	0	33,066	54.00
60.00	06000	LABORATORY	0	3,693	0	0	20,023	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,209	0	0	978	65.00
66.00	06600	PHYSICAL THERAPY	0	4,926	0	0	8,572	66.00
69.00	06900	ELECTROCARDIOLOGY	0	346	0	0	2,338	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	7,826	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	5,816	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	56,061	14,161	73.00
74.00	07400	RENAL DIALYSIS	0	1,862	2,548	0	1,021	74.00
		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
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	3,335	0	0	989	90.00
90.01	04951	CHEMO/PAIN	0	9,111	13,023	0	3,245	90.01
90.02	09002	SENIOR CARE	0	335	639	0	405	90.02
90.03	09003	SLEEP LAB	0	0	0	0	0	90.03
90.04	09001	ORTHOPEDICS	0	4,939	0	0	616	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	8,803	11,038	0	7,302	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,440	9,969	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	176,099	88,872	82,656	56,061	137,277	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	548	0	0	192.00
192.01	19202	HOME HEALTHCARE SVC	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	0	0	0	0	192.02
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)	176,099	88,872	83,204	56,061	137,277	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/23/2024 4:01 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
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
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	8,663					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,663	1,165,019	0	1,165,019		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	853,670	0	853,670		50.00
53.00	05300	ANESTHESIOLOGY	0	24,131	0	24,131		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	520,404	0	520,404		54.00
60.00	06000	LABORATORY	0	243,233	0	243,233		60.00
65.00	06500	RESPIRATORY THERAPY	0	41,815	0	41,815		65.00
66.00	06600	PHYSICAL THERAPY	0	1,350,572	0	1,350,572		66.00
69.00	06900	ELECTROCARDIOLOGY	0	34,189	0	34,189		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	120,556	0	120,556		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	48,161	0	48,161		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	144,695	0	144,695		73.00
74.00	07400	RENAL DIALYSIS	0	16,554	0	16,554		74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	141,165	0	141,165		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	78,106	0	78,106		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	7,445	0	7,445		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	550,669	0	550,669		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	82,296	0	82,296		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	14	0	14		88.05
90.00	09000	CLINIC	0	47,591	0	47,591		90.00
90.01	04951	CHEMO/PAIN	0	151,658	0	151,658		90.01
90.02	09002	SENIOR CARE	0	12,455	0	12,455		90.02
90.03	09003	SLEEP LAB	0	0	0	0		90.03
90.04	09001	ORTHOPEDICS	0	107,434	0	107,434		90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	24,734	0	24,734		90.05
91.00	09100	EMERGENCY	0	389,604	0	389,604		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	40,706	0	40,706		95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	108	0	108		96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,663	6,196,984	0	6,196,984		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	90,542	0	90,542		192.00
192.01	19202	HOME HEALTHCARE SVC	0	5,902	0	5,902		192.01
192.02	19201	NAL CLINIC	0	126,611	0	126,611		192.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	8,663	6,420,039	0	6,420,039		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/23/2024 4:01 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	135,968					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		135,968				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	927	927	37,256,075			4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	20,433	20,433	5,986,416	-14,203,476	101,555,951	5.01
5.02	00560	ADMITTING	3,290	3,290	2,081,253	0	6,299,291	5.02
7.00	00700	OPERATION OF PLANT	11,861	11,861	1,249,995	0	3,866,766	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	971	971	0	0	180,368	8.00
9.00	00900	HOUSEKEEPING	683	683	1,098,044	0	1,922,112	9.00
10.00	01000	DIETARY	3,068	3,068	319,366	0	717,301	10.00
11.00	01100	CAFETERIA	1,396	1,396	533,392	0	1,192,539	11.00
13.00	01300	NURSING ADMINISTRATION	1,380	1,380	350,255	0	589,369	13.00
15.00	01500	PHARMACY	871	871	395,181	0	658,982	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,231	2,231	692,160	0	1,181,549	16.00
17.00	01700	SOCIAL SERVICE	156	156	0	0	8,068	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,006	14,006	4,712,091	0	6,955,617	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,071	14,071	3,109,816	0	1,589,654	50.00
53.00	05300	ANESTHESIOLOGY	119	119	1,020,800	0	990,961	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,365	7,365	2,549,839	0	4,993,477	54.00
60.00	06000	LABORATORY	3,069	3,069	1,079,793	0	3,369,943	60.00
65.00	06500	RESPIRATORY THERAPY	381	381	645,895	0	1,083,514	65.00
66.00	06600	PHYSICAL THERAPY	23,407	23,407	1,440,249	0	3,243,899	66.00
69.00	06900	ELECTROCARDIOLOGY	524	524	101,202	0	182,829	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	8,330,771	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	4,425,188	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	5,066,890	73.00
74.00	07400	RENAL DIALYSIS	0	0	544,301	0	1,095,481	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	14,749,232	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,500	1,500	0	0	760,787	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	778,030	88.02
88.03	08803	RURAL HEALTH CLINIC IV	10,903	10,903	0	0	3,747,449	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,591	1,591	0	0	749,609	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	1,423	88.05
90.00	09000	CLINIC	615	615	975,046	0	840,512	90.00
90.01	04951	CHEMO/PAIN	1,544	1,544	2,663,946	0	3,774,640	90.01
90.02	09002	SENIOR CARE	0	0	98,094	0	732,947	90.02
90.03	09003	SLEEP LAB	0	0	0	0	0	90.03
90.04	09001	ORTHOPEDICS	1,843	1,843	1,444,228	0	840,128	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	428	428	0	0	19,549	90.05
91.00	09100	EMERGENCY	5,154	5,154	2,574,090	0	5,186,088	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	1,590,623	0	2,448,372	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	11,311	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	133,787	133,787	37,256,075	-14,203,476	92,584,646	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	7,667,827	192.00
192.01	19202	HOME HEALTHCARE SVC	0	0	0	0	616,734	192.01
192.02	19201	NAL CLINIC	2,181	2,181	0	0	686,744	192.02
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)	3,758,619	2,661,420	10,541,987		14,203,476	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.643409	19.573870	0.282960		0.139859	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			43,770		971,819	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001175		0.009569	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: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/23/2024 4:01 pm

		Cost Center Description	ADMITTING (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			5.02	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING	43,642,627					5.02
7.00	00700	OPERATION OF PLANT	0	83,586				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	971	100			8.00
9.00	00900	HOUSEKEEPING	0	683	0	85,934		9.00
10.00	01000	DIETARY	0	3,068	0	3,068	100	10.00
11.00	01100	CAFETERIA	0	1,396	0	1,396	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,380	0	1,380	0	13.00
15.00	01500	PHARMACY	0	871	0	871	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,231	0	2,231	0	16.00
17.00	01700	SOCIAL SERVICE	0	156	0	156	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,052,268	14,006	100	14,006	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,639,159	14,071	0	14,071	0	50.00
53.00	05300	ANESTHESIOLOGY	0	119	0	119	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,497,846	7,365	0	7,365	0	54.00
60.00	06000	LABORATORY	3,419,474	3,069	0	3,069	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,306,888	381	0	381	0	65.00
66.00	06600	PHYSICAL THERAPY	3,210,861	23,407	0	23,407	0	66.00
69.00	06900	ELECTROCARDIOLOGY	159,403	524	0	524	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,606,597	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,200,726	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		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
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	926,897	0	0	615	0	90.00
90.01	04951	CHEMO/PAIN	2,622,576	0	0	1,544	0	90.01
90.02	09002	SENIOR CARE	789,929	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0	0	0	0	0	90.03
90.04	09001	ORTHOPEDICS	780,815	0	0	1,843	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	198,168	428	0	428	0	90.05
91.00	09100	EMERGENCY	5,231,020	5,154	0	5,154	0	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
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,642,627	79,280	100	81,628	100	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,125	0	2,125	0	192.00
192.01	19202	HOME HEALTHCARE SVC	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	2,181	0	2,181	0	192.02
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)	7,180,304	4,407,568	256,796	2,226,952	1,058,907	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.164525	52.730936	2,567.960000	25.914679	10,589.070000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	218,068	598,514	54,527	56,823	176,099	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.004997	7.160457	545.270000	0.661240	1,760.990000	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: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/23/2024 4:01 pm

		Cost Center Description	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NRSNG SALARIES)	PHARMACY (COST REQU.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PAT DAYS)	
			11.00	13.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
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	25,987,609					11.00
13.00	01300	NURSING ADMINISTRATION	350,255	12,780,606				13.00
15.00	01500	PHARMACY	395,181	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	692,160	0	0	178,943,374		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	100	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,712,091	4,229,695	0	5,070,041	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,109,816	2,750,013	0	30,797,538	0	50.00
53.00	05300	ANESTHESIOLOGY	1,020,800	0	0	4,443,527	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,549,839	0	0	43,076,651	0	54.00
60.00	06000	LABORATORY	1,079,793	0	0	26,104,984	0	60.00
65.00	06500	RESPIRATORY THERAPY	645,895	0	0	1,275,301	0	65.00
66.00	06600	PHYSICAL THERAPY	1,440,249	0	0	11,175,873	0	66.00
69.00	06900	ELECTROCARDIOLOGY	101,202	0	0	3,048,617	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,203,128	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	7,583,204	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	18,462,497	0	73.00
74.00	07400	RENAL DIALYSIS	544,301	391,433	0	1,331,053	0	74.00
		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
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	975,046	0	0	1,289,271	0	90.00
90.01	04951	CHEMO/PAIN	2,663,946	2,000,419	0	4,230,173	0	90.01
90.02	09002	SENIOR CARE	98,094	98,094	0	527,617	0	90.02
90.03	09003	SLEEP LAB	0	0	0	0	0	90.03
90.04	09001	ORTHOPEDICS	1,444,228	0	0	802,756	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	0	0	321	0	90.05
91.00	09100	EMERGENCY	2,574,090	1,695,505	0	9,520,822	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,590,623	1,531,287	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,987,609	12,696,446	100	178,943,374	100	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	84,160	0	0	0	192.00
192.01	19202	HOME HEALTHCARE SVC	0	0	0	0	0	192.01
192.02	19201	NAL CLINIC	0	0	0	0	0	192.02
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)	1,469,115	800,129	841,988	1,561,386	21,465	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.056531	0.062605	8,419.880000	0.008726	214.650000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	88,872	83,204	56,061	137,277	8,663	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003420	0.006510	560.610000	0.000767	86.630000	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: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/23/2024 4:01 pm

Title XVIII | Hospital | Cost

		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	12,102,803		12,102,803	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,804,991		3,804,991	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1,235,396		1,235,396	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,531,052		7,531,052	0	0	54.00
60.00	06000	LABORATORY	4,934,046		4,934,046	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,527,673	0	1,527,673	0	0	65.00
66.00	06600	PHYSICAL THERAPY	6,245,653	0	6,245,653	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	308,158		308,158	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,671,886		10,671,886	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,110,261		5,110,261	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,634,281		7,634,281	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,315,585		1,315,585	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	16,812,009		16,812,009	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	867,190		867,190	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	886,844		886,844	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	4,271,563		4,271,563	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	854,449		854,449	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1,622		1,622	0	0	88.05
90.00	09000	CLINIC	1,192,871		1,192,871	0	0	90.00
90.01	04951	CHEMO/PAIN	5,086,792		5,086,792	0	0	90.01
90.02	09002	SENIOR CARE	981,709		981,709	0	0	90.02
90.03	09003	SLEEP LAB	0		0	0	0	90.03
90.04	09001	ORTHOPEDICS	1,222,501		1,222,501	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	88,550		88,550	0	0	90.05
91.00	09100	EMERGENCY	7,512,124		7,512,124	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,071,496		5,071,496		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,976,585		2,976,585	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	12,893		12,893	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	110,260,983	0	110,260,983	0	0	200.00
201.00		Less Observation Beds	5,071,496		5,071,496		0	201.00
202.00		Total (see instructions)	105,189,487	0	105,189,487	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/23/2024 4:01 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	3,241,823		3,241,823			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,343,054	29,454,484	30,797,538	0.123549	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	187,228	4,256,299	4,443,527	0.278021	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,060,672	42,015,979	43,076,651	0.174829	0.000000	54.00
60.00	06000	LABORATORY	1,020,800	25,084,184	26,104,984	0.189008	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	388,885	886,416	1,275,301	1.197892	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	679,689	10,496,184	11,175,873	0.558851	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	27,556	3,021,061	3,048,617	0.101081	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	603,752	9,599,376	10,203,128	1.045943	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	497,955	7,085,249	7,583,204	0.673892	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,406,269	17,056,228	18,462,497	0.413502	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	1,331,053	1,331,053	0.988379	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	11,488,975	11,488,975			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	857,901	857,901			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	365,688	365,688			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	5,285,721	5,285,721			88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,403,565	1,403,565			88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0			88.05
90.00	09000	CLINIC	30,238	1,259,033	1,289,271	0.925229	0.000000	90.00
90.01	04951	CHEMO/PAIN	500	4,229,673	4,230,173	1.202502	0.000000	90.01
90.02	09002	SENIOR CARE	0	527,617	527,617	1.860647	0.000000	90.02
90.03	09003	SLEEP LAB	0	0	0	0.000000	0.000000	90.03
90.04	09001	ORTHOPEDICS	0	802,756	802,756	1.522880	0.000000	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	321	321	275.856698	0.000000	90.05
91.00	09100	EMERGENCY	762	9,520,060	9,520,822	0.789021	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,828,218	1,828,218	2.774011	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,397,346	2,397,346	1.241617	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	3,522	3,522	3.660704	0.000000	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	10,489,183	190,256,909	200,746,092			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,489,183	190,256,909	200,746,092			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/23/2024 4:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
		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
88.04	08804	RURAL HEALTH CLINIC V		88.04
88.05	08805	RURAL HEALTH CLINIC VI		88.05
90.00	09000	CLINIC	0.000000	90.00
90.01	04951	CHEMO/PAIN	0.000000	90.01
90.02	09002	SENIOR CARE	0.000000	90.02
90.03	09003	SLEEP LAB	0.000000	90.03
90.04	09001	ORTHOPEDICS	0.000000	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0.000000	90.05
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0.000000	96.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/23/2024 4:01 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,102,803		12,102,803	0	12,102,803	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,804,991		3,804,991	0	3,804,991	50.00
53.00	05300	ANESTHESIOLOGY	1,235,396		1,235,396	0	1,235,396	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,531,052		7,531,052	0	7,531,052	54.00
60.00	06000	LABORATORY	4,934,046		4,934,046	0	4,934,046	60.00
65.00	06500	RESPIRATORY THERAPY	1,527,673	0	1,527,673	0	1,527,673	65.00
66.00	06600	PHYSICAL THERAPY	6,245,653	0	6,245,653	0	6,245,653	66.00
69.00	06900	ELECTROCARDIOLOGY	308,158		308,158	0	308,158	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,671,886		10,671,886	0	10,671,886	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,110,261		5,110,261	0	5,110,261	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,634,281		7,634,281	0	7,634,281	73.00
74.00	07400	RENAL DIALYSIS	1,315,585		1,315,585	0	1,315,585	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	16,812,009		16,812,009	0	16,812,009	88.00
88.01	08801	RURAL HEALTH CLINIC II	867,190		867,190	0	867,190	88.01
88.02	08802	RURAL HEALTH CLINIC III	886,844		886,844	0	886,844	88.02
88.03	08803	RURAL HEALTH CLINIC IV	4,271,563		4,271,563	0	4,271,563	88.03
88.04	08804	RURAL HEALTH CLINIC V	854,449		854,449	0	854,449	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1,622		1,622	0	1,622	88.05
90.00	09000	CLINIC	1,192,871		1,192,871	0	1,192,871	90.00
90.01	04951	CHEMO/PAIN	5,086,792		5,086,792	0	5,086,792	90.01
90.02	09002	SENIOR CARE	981,709		981,709	0	981,709	90.02
90.03	09003	SLEEP LAB	0		0	0	0	90.03
90.04	09001	ORTHOPEDICS	1,222,501		1,222,501	0	1,222,501	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	88,550		88,550	0	88,550	90.05
91.00	09100	EMERGENCY	7,512,124		7,512,124	0	7,512,124	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,071,496		5,071,496		5,071,496	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,976,585		2,976,585	0	2,976,585	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	12,893		12,893	0	12,893	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	110,260,983	0	110,260,983	0	110,260,983	200.00
201.00		Less Observation Beds	5,071,496		5,071,496		5,071,496	201.00
202.00		Total (see instructions)	105,189,487	0	105,189,487	0	105,189,487	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/23/2024 4:01 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,241,823		3,241,823			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,343,054	29,454,484	30,797,538	0.123549	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	187,228	4,256,299	4,443,527	0.278021	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,060,672	42,015,979	43,076,651	0.174829	0.000000	54.00
60.00	06000	LABORATORY	1,020,800	25,084,184	26,104,984	0.189008	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	388,885	886,416	1,275,301	1.197892	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	679,689	10,496,184	11,175,873	0.558851	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	27,556	3,021,061	3,048,617	0.101081	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	603,752	9,599,376	10,203,128	1.045943	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	497,955	7,085,249	7,583,204	0.673892	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,406,269	17,056,228	18,462,497	0.413502	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	1,331,053	1,331,053	0.988379	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	11,488,975	11,488,975	1.463317	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	857,901	857,901	1.010828	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	365,688	365,688	2.425138	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	5,285,721	5,285,721	0.808133	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,403,565	1,403,565	0.608771	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0.000000	0.000000	88.05
90.00	09000	CLINIC	30,238	1,259,033	1,289,271	0.925229	0.000000	90.00
90.01	04951	CHEMO/PAIN	500	4,229,673	4,230,173	1.202502	0.000000	90.01
90.02	09002	SENIOR CARE	0	527,617	527,617	1.860647	0.000000	90.02
90.03	09003	SLEEP LAB	0	0	0	0.000000	0.000000	90.03
90.04	09001	ORTHOPEDICS	0	802,756	802,756	1.522880	0.000000	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	321	321	275.856698	0.000000	90.05
91.00	09100	EMERGENCY	762	9,520,060	9,520,822	0.789021	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,828,218	1,828,218	2.774011	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,397,346	2,397,346	1.241617	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	3,522	3,522	3.660704	0.000000	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	10,489,183	190,256,909	200,746,092			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,489,183	190,256,909	200,746,092			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/23/2024 4:01 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		88.05
90.00	09000	CLINIC	0.000000		90.00
90.01	04951	CHEMO/PAIN	0.000000		90.01
90.02	09002	SENIOR CARE	0.000000		90.02
90.03	09003	SLEEP LAB	0.000000		90.03
90.04	09001	ORTHOPEDICS	0.000000		90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0.000000		90.05
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0.000000		96.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/23/2024 4:01 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	853,670	30,797,538	0.027719	679,700	18,841	50.00
53.00	05300	ANESTHESIOLOGY	24,131	4,443,527	0.005431	87,058	473	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	520,404	43,076,651	0.012081	561,503	6,784	54.00
60.00	06000	LABORATORY	243,233	26,104,984	0.009317	563,356	5,249	60.00
65.00	06500	RESPIRATORY THERAPY	41,815	1,275,301	0.032788	202,601	6,643	65.00
66.00	06600	PHYSICAL THERAPY	1,350,572	11,175,873	0.120847	372,821	45,054	66.00
69.00	06900	ELECTROCARDIOLOGY	34,189	3,048,617	0.011215	15,953	179	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	120,556	10,203,128	0.011816	307,002	3,628	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	48,161	7,583,204	0.006351	254,503	1,616	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	144,695	18,462,497	0.007837	700,249	5,488	73.00
74.00	07400	RENAL DIALYSIS	16,554	1,331,053	0.012437	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	141,165	11,488,975	0.012287	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	78,106	857,901	0.091043	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	7,445	365,688	0.020359	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	550,669	5,285,721	0.104180	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	82,296	1,403,565	0.058634	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	14	0	0.000000	0	0	88.05
90.00	09000	CLINIC	47,591	1,289,271	0.036913	0	0	90.00
90.01	04951	CHEMO/PAIN	151,658	4,230,173	0.035851	24	1	90.01
90.02	09002	SENIOR CARE	12,455	527,617	0.023606	0	0	90.02
90.03	09003	SLEEP LAB	0	0	0.000000	0	0	90.03
90.04	09001	ORTHOPEDICS	107,434	802,756	0.133831	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	24,734	321	77.052960	0	0	90.05
91.00	09100	EMERGENCY	389,604	9,520,822	0.040921	251	10	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	488,182	1,828,218	0.267026	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	108	3,522	0.030664	0	0	96.00
200.00		Total (lines 50 through 199)	5,479,441	195,106,923		3,745,021	93,966	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/23/2024 4:01 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		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
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	CHEMO/PAIN	0	0	0	0	0	90.01
90.02	09002	SENIOR CARE	0	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0	0	0	0	0	90.03
90.04	09001	ORTHOPEDICS	0	0	0	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	90.05
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
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
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: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/23/2024 4:01 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	30,797,538	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,443,527	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	43,076,651	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	26,104,984	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,275,301	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,175,873	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,048,617	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,203,128	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	7,583,204	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	18,462,497	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,331,053	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	11,488,975	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	857,901	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	365,688	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	5,285,721	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	1,403,565	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0.000000	88.05
90.00	09000	CLINIC	0	0	0	1,289,271	0.000000	90.00
90.01	04951	CHEMO/PAIN	0	0	0	4,230,173	0.000000	90.01
90.02	09002	SENIOR CARE	0	0	0	527,617	0.000000	90.02
90.03	09003	SLEEP LAB	0	0	0	0	0.000000	90.03
90.04	09001	ORTHOPEDICS	0	0	0	802,756	0.000000	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	0	0	321	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	9,520,822	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,828,218	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	3,522	0.000000	96.00
200.00		Total (lines 50 through 199)	0	0	0	195,106,923		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/23/2024 4:01 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	679,700	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	87,058	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	561,503	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	563,356	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	202,601	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	372,821	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	15,953	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	307,002	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	254,503	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	700,249	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		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
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0	88.05
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04951	CHEMO/PAIN	0.000000	24	0	0	0	90.01
90.02	09002	SENIOR CARE	0.000000	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0.000000	0	0	0	0	90.03
90.04	09001	ORTHOPEDICS	0.000000	0	0	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	251	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
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		3,745,021	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/23/2024 4:01 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	0.123549	0	9,533,991	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.278021	0	1,115,691	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174829	0	11,058,267	0	0	54.00
60.00	06000	LABORATORY	0.189008	0	6,317,052	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.197892	0	236,069	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.558851	0	3,039,219	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.101081	0	790,391	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.045943	0	2,800,495	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.673892	0	2,973,486	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413502	0	7,745,988	5,586	0	73.00
74.00	07400	RENAL DIALYSIS	0.988379	0	0	0	0	74.00
		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
88.04	08804	RURAL HEALTH CLINIC V						88.04
88.05	08805	RURAL HEALTH CLINIC VI						88.05
90.00	09000	CLINIC	0.925229	0	564,832	0	0	90.00
90.01	04951	CHEMO/PAIN	1.202502	0	767,855	0	0	90.01
90.02	09002	SENIOR CARE	1.860647	0	523,334	0	0	90.02
90.03	09003	SLEEP LAB	0.000000	0	0	0	0	90.03
90.04	09001	ORTHOPEDICS	1.522880	0	245,812	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	275.856698	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.789021	0	2,102,737	416	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.774011	0	420,160	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.241617		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	3.660704	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	50,235,379	6,002	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	50,235,379	6,002	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/23/2024 4:01 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	1,177,915	0		50.00
53.00	05300	ANESTHESIOLOGY	310,186	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,933,306	0		54.00
60.00	06000	LABORATORY	1,193,973	0		60.00
65.00	06500	RESPIRATORY THERAPY	282,785	0		65.00
66.00	06600	PHYSICAL THERAPY	1,698,471	0		66.00
69.00	06900	ELECTROCARDIOLOGY	79,894	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,929,158	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,003,808	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,202,982	2,310		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		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
88.04	08804	RURAL HEALTH CLINIC V				88.04
88.05	08805	RURAL HEALTH CLINIC VI				88.05
90.00	09000	CLINIC	522,599	0		90.00
90.01	04951	CHEMO/PAIN	923,347	0		90.01
90.02	09002	SENIOR CARE	973,740	0		90.02
90.03	09003	SLEEP LAB	0	0		90.03
90.04	09001	ORTHOPEDICS	374,342	0		90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	0		90.05
91.00	09100	EMERGENCY	1,659,104	328		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,165,528	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	0		96.00
200.00		Subtotal (see instructions)	20,431,138	2,638		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	20,431,138	2,638		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/23/2024 4:01 pm

Title XIX | 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	0.123549	0	0	932,049	0	50.00
53.00	05300	ANESTHESIOLOGY	0.278021	0	0	100,901	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174829	0	0	1,639,762	0	54.00
60.00	06000	LABORATORY	0.189008	0	0	851,868	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.197892	0	0	30,456	0	65.00
66.00	06600	PHYSICAL THERAPY	0.558851	0	0	275,783	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.101081	0	0	196,717	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.045943	0	0	490,111	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.673892	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413502	0	0	842,064	0	73.00
74.00	07400	RENAL DIALYSIS	0.988379	0	0	0	0	74.00
		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
88.04	08804	RURAL HEALTH CLINIC V						88.04
88.05	08805	RURAL HEALTH CLINIC VI						88.05
90.00	09000	CLINIC	0.925229	0	0	78,647	0	90.00
90.01	04951	CHEMO/PAIN	1.202502	0	0	67,172	0	90.01
90.02	09002	SENIOR CARE	1.860647	0	0	70	0	90.02
90.03	09003	SLEEP LAB	0.000000	0	0	0	0	90.03
90.04	09001	ORTHOPEDICS	1.522880	0	0	25,668	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	275.856698	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.789021	0	0	501,014	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.774011	0	0	40,121	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.241617	0	0			95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	3.660704	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	0	6,072,403	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	6,072,403	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/23/2024 4:01 pm

Title XIX | 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	0	115,154		50.00
53.00	05300	ANESTHESIOLOGY	0	28,053		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	286,678		54.00
60.00	06000	LABORATORY	0	161,010		60.00
65.00	06500	RESPIRATORY THERAPY	0	36,483		65.00
66.00	06600	PHYSICAL THERAPY	0	154,122		66.00
69.00	06900	ELECTROCARDIOLOGY	0	19,884		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	512,628		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	348,195		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		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
88.04	08804	RURAL HEALTH CLINIC V				88.04
88.05	08805	RURAL HEALTH CLINIC VI				88.05
90.00	09000	CLINIC	0	72,766		90.00
90.01	04951	CHEMO/PAIN	0	80,774		90.01
90.02	09002	SENIOR CARE	0	130		90.02
90.03	09003	SLEEP LAB	0	0		90.03
90.04	09001	ORTHOPEDICS	0	39,089		90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	0	0		90.05
91.00	09100	EMERGENCY	0	395,311		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	111,296		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	2,361,573		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	2,361,573		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/23/2024 4:01 pm

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,094	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,712	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)	2,008	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	277	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	1,105	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)	1,182	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)	206	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	208.70	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	208.70	20.00
21.00	Total general inpatient routine service cost (see instructions)	12,102,803	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)	230,614	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,055,030	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	11,047,773	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)	11,047,773	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)	2,976.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,517,904	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)	3,517,904	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/23/2024 4:01 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)	1,547,880	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)	5,065,784	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)	613,103	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	613,103	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)	1,704	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,976.23	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	5,071,496	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/23/2024 4:01 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	1,165,019	12,102,803	0.096260	5,071,496	488,182	90.00
91.00	Nursing Program cost	0	12,102,803	0.000000	5,071,496	0	91.00
92.00	Allied health cost	0	12,102,803	0.000000	5,071,496	0	92.00
93.00	All other Medical Education	0	12,102,803	0.000000	5,071,496	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/23/2024 4:01 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		1,254,580		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.123549	679,700	83,976	50.00
53.00	05300	ANESTHESIOLOGY	0.278021	87,058	24,204	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174829	561,503	98,167	54.00
60.00	06000	LABORATORY	0.189008	563,356	106,479	60.00
65.00	06500	RESPIRATORY THERAPY	1.197892	202,601	242,694	65.00
66.00	06600	PHYSICAL THERAPY	0.558851	372,821	208,351	66.00
69.00	06900	ELECTROCARDIOLOGY	0.101081	15,953	1,613	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.045943	307,002	321,107	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.673892	254,503	171,508	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413502	700,249	289,554	73.00
74.00	07400	RENAL DIALYSIS	0.988379	0	0	74.00
		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
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0	88.05
90.00	09000	CLINIC	0.925229	0	0	90.00
90.01	04951	CHEMO/PAIN	1.202502	24	29	90.01
90.02	09002	SENIOR CARE	1.860647	0	0	90.02
90.03	09003	SLEEP LAB	0.000000	0	0	90.03
90.04	09001	ORTHOPEDICS	1.522880	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	275.856698	0	0	90.05
91.00	09100	EMERGENCY	0.789021	251	198	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.774011	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	3.660704	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,745,021	1,547,880	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)		3,745,021		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1320 | Component CCN: 14-Z320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/23/2024 4:01 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	0.123549	542	67	50.00
53.00	05300	ANESTHESIOLOGY	0.278021	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174829	12,422	2,172	54.00
60.00	06000	LABORATORY	0.189008	31,552	5,964	60.00
65.00	06500	RESPIRATORY THERAPY	1.197892	12,286	14,717	65.00
66.00	06600	PHYSICAL THERAPY	0.558851	116,989	65,379	66.00
69.00	06900	ELECTROCARDIOLOGY	0.101081	2,193	222	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.045943	10,328	10,802	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.673892	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413502	68,238	28,217	73.00
74.00	07400	RENAL DIALYSIS	0.988379	0	0	74.00
		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
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0	88.05
90.00	09000	CLINIC	0.925229	0	0	90.00
90.01	04951	CHEMO/PAIN	1.202502	0	0	90.01
90.02	09002	SENIOR CARE	1.860647	0	0	90.02
90.03	09003	SLEEP LAB	0.000000	0	0	90.03
90.04	09001	ORTHOPEDICS	1.522880	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	275.856698	0	0	90.05
91.00	09100	EMERGENCY	0.789021	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.774011	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	3.660704	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		254,550	127,540	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)		254,550		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/23/2024 4:01 pm

Title XIX | 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		12,112		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.123549	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.278021	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174829	6,557	1,146	54.00
60.00	06000	LABORATORY	0.189008	5,137	971	60.00
65.00	06500	RESPIRATORY THERAPY	1.197892	6,386	7,650	65.00
66.00	06600	PHYSICAL THERAPY	0.558851	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.101081	1,990	201	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.045943	3,273	3,423	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.673892	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413502	5,420	2,241	73.00
74.00	07400	RENAL DIALYSIS	0.988379	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.463317	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.010828	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2.425138	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.808133	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.608771	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000	0	0	88.05
90.00	09000	CLINIC	0.925229	0	0	90.00
90.01	04951	CHEMO/PAIN	1.202502	0	0	90.01
90.02	09002	SENIOR CARE	1.860647	0	0	90.02
90.03	09003	SLEEP LAB	0.000000	0	0	90.03
90.04	09001	ORTHOPEDICS	1.522880	0	0	90.04
90.05	09004	BEHAVIORAL HEALTH CLINIC	275.856698	0	0	90.05
91.00	09100	EMERGENCY	0.789021	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.774011	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP. - RENTED	3.660704	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		28,763	15,632	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)		28,763		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E Part B Date/Time Prepared: 5/23/2024 4:01 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	20,433,776	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	20,433,776	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)	20,638,114	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)	100,720	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	8,732,889	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)	11,804,505	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	11,804,505	30.00
31.00	Primary payer payments	1,701	31.00
32.00	Subtotal (line 30 minus line 31)	11,802,804	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)	285,477	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	185,560	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	148,945	36.00
37.00	Subtotal (see instructions)	11,988,364	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)	11,988,364	40.00
40.01	Sequestration adjustment (see instructions)	239,767	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	10,602,193	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)	1,146,404	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	99,917	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1320	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/23/2024 4:01 pm
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/23/2024 4:01 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		3,994,475		10,304,251	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	12/15/2023	18,204	12/15/2023	79,774	3.01
3.02		08/24/2023	72,016	08/24/2023	218,168	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)		90,220		297,942	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)		4,084,695		10,602,193	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		444,076		1,146,404	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,528,771		11,748,597	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: 14-1320 | Component CCN: 14-Z320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/23/2024 4:01 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		582,734		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	12/15/2023	14,680		0	3.01
3.02		08/24/2023	31,241		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)		45,921		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)		628,655		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		102,669		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		731,324		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1320	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/23/2024 4:01 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: 14-1320 | Component CCN: 14-Z320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/23/2024 4:01 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)	619,234	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)	128,815	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	206	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)	748,049	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	748,049	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)	748,049	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,800	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	746,249	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)	746,249	0	19.00
19.01	Sequestration adjustment (see instructions)	14,925	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	628,655	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)	102,669	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: 14-1320	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/23/2024 4:01 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,065,784	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)	5,065,784	4.00
5.00	Primary payer payments	5,251	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,111,191	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)	5,111,191	19.00
20.00	Deductibles (exclude professional component)	499,495	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,611,696	22.00
23.00	Coinsurance	800	23.00
24.00	Subtotal (line 22 minus line 23)	4,610,896	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	15,844	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	10,299	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,536	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,621,195	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)	4,621,195	30.00
30.01	Sequestration adjustment (see instructions)	92,424	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	4,084,695	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)	444,076	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	5,545	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/23/2024 4:01 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	1,619,371	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	43,522,958	0	0	0	4.00
5.00	Other receivable	4,201,168	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-28,286,019	0	0	0	6.00
7.00	Inventory	3,285,093	0	0	0	7.00
8.00	Prepaid expenses	970,534	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	25,313,105	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,626,832	0	0	0	12.00
13.00	Land improvements	4,293,681	0	0	0	13.00
14.00	Accumulated depreciation	-2,505,524	0	0	0	14.00
15.00	Buildings	73,200,538	0	0	0	15.00
16.00	Accumulated depreciation	-27,136,731	0	0	0	16.00
17.00	Leasehold improvements	7,632,592	0	0	0	17.00
18.00	Accumulated depreciation	-233,511	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	29,111,249	0	0	0	23.00
24.00	Accumulated depreciation	-21,929,938	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	64,059,188	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	89,372,293	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	7,370,534	0	0	0	37.00
38.00	Salaries, wages, and fees payable	152,017	0	0	0	38.00
39.00	Payroll taxes payable	5,790,171	0	0	0	39.00
40.00	Notes and loans payable (short term)	22,366,108	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,727,068	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	38,405,898	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	38,405,898	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	50,966,395				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)	50,966,395	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	89,372,293	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/23/2024 4:01 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		52,177,991		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,211,596				2.00
3.00	Total (sum of line 1 and line 2)		50,966,395		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		50,966,395		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		50,966,395		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/23/2024 4:01 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	8,396,264		8,396,264	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,396,264		8,396,264	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)	8,396,264		8,396,264	17.00
18.00	Ancillary services	2,830,733	191,788,477	194,619,210	18.00
19.00	Outpatient services	319,694	30,870,452	31,190,146	19.00
20.00	RURAL HEALTH CLINIC	0	11,488,975	11,488,975	20.00
20.01	RURAL HEALTH CLINIC II	0	857,901	857,901	20.01
20.02	RURAL HEALTH CLINIC III	0	365,688	365,688	20.02
20.03	RURAL HEALTH CLINIC IV	0	5,285,721	5,285,721	20.03
20.04	RURAL HEALTH CLINIC V	0	1,403,565	1,403,565	20.04
20.05	RURAL HEALTH CLINIC VI	0	0	0	20.05
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				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				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,546,691	242,060,779	253,607,470	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		127,035,272		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		127,035,272		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-3 | Date/Time Prepared: 5/23/2024 4:01 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	253,607,470	1.00
2.00	Less contractual allowances and discounts on patients' accounts	135,955,949	2.00
3.00	Net patient revenues (line 1 minus line 2)	117,651,521	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	127,035,272	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-9,383,751	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	1,424,079	6.00
7.00	Income from investments	61,783	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	16,498	10.00
11.00	Rebates and refunds of expenses	16,160	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	194,469	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	15,184	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	6,888	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	111,300	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	6,325,794	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	8,172,155	25.00
26.00	Total (line 5 plus line 25)	-1,211,596	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,211,596	29.00

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

Provider CCN: 14-1320
Component CCN: 14-2341

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

Worksheet I-1
Date/Time Prepared:
5/23/2024 4:01 pm

Renal Dialysis

		Total Costs	Basis	Statistics	FTEs per 2080 Hours	
		1.00	2.00	3.00	4.00	
1.00	REGISTERED NURSES	123,783	HOURS OF SERVICE	3,076.00	1.48	1.00
2.00	LICENSED PRACTICAL NURSES	0	HOURS OF SERVICE	0.00	0.00	2.00
3.00	NURSES AIDES	0	HOURS OF SERVICE	0.00	0.00	3.00
4.00	TECHNICIANS	91,751	HOURS OF SERVICE	3,394.00	1.63	4.00
5.00	SOCIAL WORKERS	75,045	HOURS OF SERVICE	1,953.00	0.94	5.00
6.00	DIETICIANS	39,175	HOURS OF SERVICE	1,002.00	0.48	6.00
7.00	PHYSICIANS	0	ACCUMULATED COST			7.00
8.00	NON-PATIENT CARE SALARY	214,546	ACCUMULATED COST			8.00
9.00	SUBTOTAL (SUM OF LINES 1-8)	544,300				9.00
10.00	EMPLOYEE BENEFITS	68,268	SALARY			10.00
11.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	1,245	SQUARE FEET			11.00
12.00	CAPITAL RELATED COSTS-MOV. EQUIP.	21,623	PERCENTAGE OF TIME			12.00
13.00	MACHINE COSTS & REPAIRS	0	PERCENTAGE OF TIME			13.00
14.00	SUPPLIES	0	REQUISITIONS			14.00
14.01	PEDIATRIC MEDICAL SUPPLIES	0	REQUISITIONS			14.01
15.00	DRUGS	0	REQUISITIONS			15.00
16.00	OTHER	306,030	ACCUMULATED COST			16.00
17.00	SUBTOTAL (SUM OF LINES 9-16)*	941,466				17.00
18.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	0	SQUARE FEET			18.00
19.00	CAPITAL RELATED COSTS-MOV. EQUIP.	0	PERCENTAGE OF TIME			19.00
20.00	EMPLOYEE BENEFITS DEPARTMENT	154,015	SALARY			20.00
21.00	ADMINISTRATIVE & GENERAL	153,213	ACCUMULATED COST			21.00
22.00	MAINT./REPAIRS-OPER-HOUSEKEEPING	0	SQUARE FEET			22.00
23.00	MEDICAL EDUCATION PROGRAM COSTS	0				23.00
24.00	CENTRAL SERVICE & SUPPLIES	0	REQUISITIONS			24.00
25.00	PHARMACY	0	REQUISITIONS			25.00
26.00	OTHER ALLOCATED COSTS	66,891	ACCUMULATED COST			26.00
27.00	SUBTOTAL (SUM OF LINES 17-26)*	1,315,585				27.00
28.00	LABORATORY (SEE INSTRUCTIONS)	0	CHARGES	0		28.00
29.00	RESPIRATORY THERAPY (SEE INSTRUCTIONS)	0	CHARGES	0		29.00
30.00	OTHER ANCILLARY SERVICE COST CENTERS	0	CHARGES	0		30.00
31.00	TOTAL COSTS (SUM OF LINES 27-30)	1,315,585				31.00

* Line 17, column 1 should agree with Worksheet A, column 7 for line 74 or line 94 as appropriate, and line 27, column 1 should agree with Worksheet B, Part I, column 24, less the sum of columns 21 and 22, for line 74 or line 94 as appropriate.

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

Provider CCN: 14-1320
Component CCN: 14-2341

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

Worksheet I-2

Date/Time Prepared: 5/23/2024 4:01 pm

Renal Dialysis

		Capital Related Costs		Direct Patient Care Salary				
		Building	Equipment	RNs	Other	Employee Benefits Department	Drugs	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Total Renal Department Costs	1,245	21,623	123,783	205,971	222,283	0	1.00
	MAINTENANCE							
2.00	Hemodialysis	1,245	21,623	123,783	205,971	222,283	0	2.00
2.01	AKI-Hemodialysis	0	0	0	0	0	0	2.01
2.02	Hemodialysis-Pediatric	0	0	0	0	0	0	2.02
3.00	Intermittent Peritoneal	0	0	0	0	0	0	3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0	0	3.01
3.02	IPD-Pediatric	0	0	0	0	0	0	3.02
	TRAINING							
4.00	Hemodialysis	0	0	0	0	0	0	4.00
4.01	Hemodialysis-Pediatric	0	0	0	0	0	0	4.01
5.00	Intermittent Peritoneal	0	0	0	0	0	0	5.00
5.01	IPD-Pediatric	0	0	0	0	0	0	5.01
6.00	CAPD	0	0	0	0	0	0	6.00
6.01	CAPD-Pediatric	0	0	0	0	0	0	6.01
7.00	CCPD	0	0	0	0	0	0	7.00
7.01	CCPD-Pediatric	0	0	0	0	0	0	7.01
	HOME							
8.00	Hemodialysis	0	0	0	0	0	0	8.00
8.01	Hemodialysis-Pediatric	0	0	0	0	0	0	8.01
9.00	Intermittent Peritoneal	0	0	0	0	0	0	9.00
9.01	IPD-Pediatric	0	0	0	0	0	0	9.01
10.00	CAPD	0	0	0	0	0	0	10.00
10.01	CAPD-Pediatric	0	0	0	0	0	0	10.01
11.00	CCPD	0	0	0	0	0	0	11.00
11.01	CCPD-Pediatric	0	0	0	0	0	0	11.01
	OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis	0	0	0	0	0	0	12.00
13.00	Method II Home Patient	0	0	0	0	0	0	13.00
14.00	ESAs (included in Renal Department)						0	14.00
15.00								15.00
16.00	Other	0	0	0	0	0	0	16.00
17.00	Total (sum of lines 2 through 16)	1,245	21,623	123,783	205,971	222,283	0	17.00
18.00	Medical Educational Program Costs							18.00
19.00	Total Renal Costs (line 17 + line 18)							19.00

		Medical Supplies	Pediatric Medical Supplies	Routine Ancillary Services	Subtotal (sum of cols. 1-8)	Overhead	Total (col. 9 + col. 10)	
		7.00	7.01	8.00	9.00	10.00	11.00	
1.00	Total Renal Department Costs	0	0	0	574,905	740,680	1,315,585	1.00
	MAINTENANCE							
2.00	Hemodialysis	0	0	0	574,905	740,680	1,315,585	2.00
2.01	AKI-Hemodialysis	0	0	0	0	0	0	2.01
2.02	Hemodialysis-Pediatric	0	0	0	0	0	0	2.02
3.00	Intermittent Peritoneal	0	0	0	0	0	0	3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0	0	3.01
3.02	IPD-Pediatric	0	0	0	0	0	0	3.02
	TRAINING							
4.00	Hemodialysis	0	0	0	0	0	0	4.00
4.01	Hemodialysis-Pediatric	0	0	0	0	0	0	4.01
5.00	Intermittent Peritoneal	0	0	0	0	0	0	5.00
5.01	IPD-Pediatric	0	0	0	0	0	0	5.01
6.00	CAPD	0	0	0	0	0	0	6.00
6.01	CAPD-Pediatric	0	0	0	0	0	0	6.01
7.00	CCPD	0	0	0	0	0	0	7.00
7.01	CCPD-Pediatric	0	0	0	0	0	0	7.01
	HOME							
8.00	Hemodialysis	0	0	0	0	0	0	8.00
8.01	Hemodialysis-Pediatric	0	0	0	0	0	0	8.01
9.00	Intermittent Peritoneal	0	0	0	0	0	0	9.00
9.01	IPD-Pediatric	0	0	0	0	0	0	9.01
10.00	CAPD	0	0	0	0	0	0	10.00
10.01	CAPD-Pediatric	0	0	0	0	0	0	10.01
11.00	CCPD	0	0	0	0	0	0	11.00
11.01	CCPD-Pediatric	0	0	0	0	0	0	11.01

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

Provider CCN: 14-1320
Component CCN: 14-2341

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

Worksheet I-2
Date/Time Prepared: 5/23/2024 4:01 pm

Renal Dialysis

		Medical Supplies	Pediatric Medical Supplies	Routine Ancillary Services	Subtotal (sum of cols. 1-8)	Overhead	Total (col. 9 + col. 10)	
		7.00	7.01	8.00	9.00	10.00	11.00	
	OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis	0	0	0	0	0	0	12.00
13.00	Method II Home Patient	0	0	0	0	0	0	13.00
14.00	ESAs (included in Renal Department)							14.00
15.00								15.00
16.00	Other	0	0	0	0	0	0	16.00
17.00	Total (sum of lines 2 through 16)	0	0	0	574,905	740,680	1,315,585	17.00
18.00	Medical Educational Program Costs						0	18.00
19.00	Total Renal Costs (line 17 + line 18)						1,315,585	19.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1320 | Component CCN: 14-2341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet I-3 | Date/Time Prepared: 5/23/2024 4:01 pm

Renal Dialysis

			Capital Related Costs		Direct Patient Care Salary			
			Building (Square Feet)	Equipment (% of Time)	RNs (Hours)	Other (Hours)	Employee Benefits Department (Salary)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	Total Renal Department Costs		1,245	21,623	123,783	205,971	222,283	1.00
	MAINTENANCE							
2.00	Hemodialysis		100	100.00	100.00	100.00	100	2.00
2.01	AKI-Hemodialysis		0	0.00	0.00	0.00	0	2.01
2.02	Hemodialysis-Pediatric		0	0.00	0.00	0.00	0	2.02
3.00	Intermittent Peritoneal		0	0.00	0.00	0.00	0	3.00
3.01	AKI-Intermittent Peritoneal		0	0.00	0.00	0.00	0	3.01
3.02	IPD-Pediatric		0	0.00	0.00	0.00	0	3.02
	TRAINING							
4.00	Hemodialysis		0	0.00	0.00	0.00	0	4.00
4.01	Hemodialysis-Pediatric		0	0.00	0.00	0.00	0	4.01
5.00	Intermittent Peritoneal		0	0.00	0.00	0.00	0	5.00
5.01	IPD-Pediatric		0	0.00	0.00	0.00	0	5.01
6.00	CAPD		0	0.00	0.00	0.00	0	6.00
6.01	CAPD-Pediatric		0	0.00	0.00	0.00	0	6.01
7.00	CCPD		0	0.00	0.00	0.00	0	7.00
7.01	CCPD-Pediatric		0	0.00	0.00	0.00	0	7.01
	HOME							
8.00	Hemodialysis		0	0.00	0.00	0.00	0	8.00
8.01	Hemodialysis-Pediatric		0	0.00	0.00	0.00	0	8.01
9.00	Intermittent Peritoneal		0	0.00	0.00	0.00	0	9.00
9.01	IPD-Pediatric		0	0.00	0.00	0.00	0	9.01
10.00	CAPD		0	0.00	0.00	0.00	0	10.00
10.01	CAPD-Pediatric		0	0.00	0.00	0.00	0	10.01
11.00	CCPD		0	0.00	0.00	0.00	0	11.00
11.01	CCPD-Pediatric		0	0.00	0.00	0.00	0	11.01
	OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	0	0	0.00	0.00	0.00	0	12.00
13.00	Method II Home Patient		0	0.00	0.00	0.00	0	13.00
14.00	ESAs							14.00
15.00								15.00
16.00	Other		0	0.00	0.00	0.00	0	16.00
17.00	Total Statistical Basis		100	100.00	100.00	100.00	100	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)		12.450000	216.230000	1,237.830000	2,059.710000	2,222.830000	18.00

		Drugs (Requist.)	Medical Supplies (Requist.)	Pediatric Medical Supplies (Requist.)	Routine Ancillary Services (Charges)	Subtotal	Overhead (Accum. Cost)	
		6.00	7.00	7.01	8.00	9.00	10.00	
1.00	Total Renal Department Costs	0	0	0	0	574,905	740,680	1.00
	MAINTENANCE							
2.00	Hemodialysis	0	0	0	0			2.00
2.01	AKI-Hemodialysis	0	0	0	0			2.01
2.02	Hemodialysis-Pediatric	0	0	0	0			2.02
3.00	Intermittent Peritoneal	0	0	0	0			3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0			3.01
3.02	IPD-Pediatric	0	0	0	0			3.02
	TRAINING							
4.00	Hemodialysis	0	0	0	0			4.00
4.01	Hemodialysis-Pediatric	0	0	0	0			4.01
5.00	Intermittent Peritoneal	0	0	0	0			5.00
5.01	IPD-Pediatric	0	0	0	0			5.01
6.00	CAPD	0	0	0	0			6.00
6.01	CAPD-Pediatric	0	0	0	0			6.01
7.00	CCPD	0	0	0	0			7.00
7.01	CCPD-Pediatric	0	0	0	0			7.01
	HOME							
8.00	Hemodialysis	0	0	0	0			8.00
8.01	Hemodialysis-Pediatric	0	0	0	0			8.01
9.00	Intermittent Peritoneal	0	0	0	0			9.00
9.01	IPD-Pediatric	0	0	0	0			9.01
10.00	CAPD	0	0	0	0			10.00
10.01	CAPD-Pediatric	0	0	0	0			10.01
11.00	CCPD	0	0	0	0			11.00
11.01	CCPD-Pediatric	0	0	0	0			11.01
	OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	0	0	0	0			12.00
13.00	Method II Home Patient	0	0	0	0			13.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1320 | Component CCN: 14-2341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet I-3 | Date/Time Prepared: 5/23/2024 4:01 pm

Renal Dialysis

		Drugs (Requist.)	Medical Supplies (Requist.)	Pediatric Medical Supplies (Requist.)	Routine Ancillary Services (Charges)	Subtotal	Overhead (Accum. Cost)	
		6.00	7.00	7.01	8.00	9.00	10.00	
14.00	ESAs							14.00
15.00								15.00
16.00	Other	0	0	0	0			16.00
17.00	Total Statistical Basis	0	0	0	0		574,905	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	0.000000	0.000000	0.000000	0.000000		1.288352	18.00

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 14-1320 | Component CCN: 14-2341 | Period: From 01/01/2023 To 12/31/2023 | Worksheet I-4 | Date/Time Prepared: 5/23/2024 4:01 pm

Rate 0 | Renal Dialysis

		Number of Total Treatments	Total Cost (from Wkst. I-2, col. 11)	Average Cost of Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Total Program Expenses (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
1.00	Maintenance - Hemodialysis	758	1,315,585	1,735.60	758	1,315,585	1.00
1.01	Maintenance - AKI Hemodialysis	0	0	0.00	0	0	1.01
2.00	Maintenance - Peritoneal Dialysis	0	0	0.00	0	0	2.00
2.01	Maintenance - AKI Peritoneal Dialysis	0	0	0.00	0	0	2.01
3.00	Training - Hemodialysis	0	0	0.00	0	0	3.00
4.00	Training - Peritoneal Dialysis	0	0	0.00	0	0	4.00
5.00	Training - CAPD	0	0	0.00	0	0	5.00
6.00	Training - CCPD	0	0	0.00	0	0	6.00
7.00	Home Program - Hemodialysis	0	0	0.00	0	0	7.00
8.00	Home Program - Peritoneal Dialysis	0	0	0.00	0	0	8.00
		Patient Weeks			Patient Weeks		
		1.00	2.00	3.00	4.00	5.00	
9.00	Home Program - CAPD	0	0	0.00	0	0	9.00
10.00	Home Program - CCPD	0	0	0.00	0	0	10.00
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	758	1,315,585		758	1,315,585	11.00
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)	758					12.00

		Total Program Payment	Average Payment Rate (col. 6 ÷ col. 4)	
		6.00	7.00	
1.00	Maintenance - Hemodialysis	201,712	266.11	1.00
1.01	Maintenance - AKI Hemodialysis	0	0.00	1.01
2.00	Maintenance - Peritoneal Dialysis	0	0.00	2.00
2.01	Maintenance - AKI Peritoneal Dialysis	0	0.00	2.01
3.00	Training - Hemodialysis	0	0.00	3.00
4.00	Training - Peritoneal Dialysis	0	0.00	4.00
5.00	Training - CAPD	0	0.00	5.00
6.00	Training - CCPD	0	0.00	6.00
7.00	Home Program - Hemodialysis	0	0.00	7.00
8.00	Home Program - Peritoneal Dialysis	0	0.00	8.00
		6.00	7.00	
9.00	Home Program - CAPD	0	0.00	9.00
10.00	Home Program - CCPD	0	0.00	10.00
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	201,712		11.00
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)			12.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B | Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet I-5 | Date/Time Prepared: 5/23/2024 4:01 pm

		1.00	2.00	
	PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B			
1.00	Total expenses related to care of program beneficiaries (see instructions)	1,315,585		1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	201,712	201,712	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due(from Wkst. I-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)	201,712	201,712	2.03
2.04	Outlier payments	140		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients	40,417	40,417	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	40,417	40,417	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012			5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013			5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014			5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Allowable bad debts (sum of lines 5 through line 5.04)	0	0	5.05
6.00	Adjusted reimbursable bad debts (see instructions)	0		6.00
7.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	40,417	8.00
9.00	Program payment (see instructions)	0	161,370	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
	PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE			
12.00	Total allowable expenses (see instructions)	1,315,585		12.00
13.00	Total composite costs (from Wkst. I-4, col. 2, line 11)	1,315,585		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	1.000000		14.00
	PART III - ESRD PAYMENTS - INFORMATION ONLY			
15.00	Low volume payment amount (see instructions)	0		15.00
16.00	TDAPA	0		16.00
17.00	TPNIES	0		17.00
18.00	CRA TPNIES	0		18.00
19.00	HDPA	0		19.00
20.00	PPA	0		20.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-3987 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/23/2024 4:01 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	4,056,162	0	4,056,162	-51,785	4,004,377	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	1,344,329	0	1,344,329	-886	1,343,443	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	2,087,410	0	2,087,410	0	2,087,410	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	1,361,055	0	1,361,055	0	1,361,055	9.00
10.00	Subtotal (sum of lines 1 through 9)	8,848,956	0	8,848,956	-52,671	8,796,285	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	14,578	14,578	0	14,578	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	203,785	203,785	0	203,785	18.00
19.00	Other Health Care Costs	0	177,987	177,987	0	177,987	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	396,350	396,350	0	396,350	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	8,848,956	396,350	9,245,306	-52,671	9,192,635	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	52,671	52,671	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	52,671	52,671	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	1,155,264	1,155,264	0	1,155,264	29.00
30.00	Administrative Costs	1,379,659	3,234,081	4,613,740	0	4,613,740	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,379,659	4,389,345	5,769,004	0	5,769,004	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	10,228,615	4,785,695	15,014,310	0	15,014,310	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-3987 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/23/2024 4:01 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	4,004,377		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	1,343,443		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	2,087,410		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	1,361,055		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	8,796,285		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	14,578		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	203,785		18.00
19.00	Other Health Care Costs	0	177,987		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	396,350		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	9,192,635		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	52,671		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	52,671		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	1,155,264		29.00
30.00	Administrative Costs	-265,078	4,348,662		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-265,078	5,503,926		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-265,078	14,749,232		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-3989 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/23/2024 4:01 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	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	250,404	0	250,404	-254	250,150	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	197,435	0	197,435	0	197,435	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	447,839	0	447,839	-254	447,585	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	4,837	4,837	0	4,837	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	10,153	10,153	0	10,153	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	14,990	14,990	0	14,990	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	447,839	14,990	462,829	-254	462,575	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	254	254	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	254	254	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	14,044	14,044	0	14,044	29.00
30.00	Administrative Costs	61,257	152,565	213,822	0	213,822	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	61,257	166,609	227,866	0	227,866	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	509,096	181,599	690,695	0	690,695	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-3989 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/23/2024 4:01 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	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	250,150		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	197,435		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	447,585		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	4,837		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	10,153		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	14,990		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	462,575		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	254		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	254		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	14,044		29.00
30.00	Administrative Costs	-734	213,088		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-734	227,132		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-734	689,961		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-8596 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/23/2024 4:01 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	388,592	0	388,592	0	388,592	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	119,453	0	119,453	-946	118,507	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	84,259	0	84,259	0	84,259	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	592,304	0	592,304	-946	591,358	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	207	207	0	207	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	9,576	9,576	0	9,576	18.00
19.00	Other Health Care Costs	0	10,053	10,053	0	10,053	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	19,836	19,836	0	19,836	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	592,304	19,836	612,140	-946	611,194	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	946	946	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	946	946	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	23,237	23,237	0	23,237	29.00
30.00	Administrative Costs	41,072	104,778	145,850	0	145,850	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	41,072	128,015	169,087	0	169,087	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	633,376	147,851	781,227	0	781,227	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-8596 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/23/2024 4:01 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	388,592		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	118,507		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	84,259		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	591,358		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	207		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	9,576		18.00
19.00	Other Health Care Costs	0	10,053		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	19,836		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	611,194		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	946		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	946		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	23,237		29.00
30.00	Administrative Costs	-3,197	142,653		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-3,197	165,890		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-3,197	778,030		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-8607 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/23/2024 4:01 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	328,312	0	328,312	0	328,312	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	941,564	0	941,564	-295	941,269	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	321,591	0	321,591	0	321,591	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	429,903	0	429,903	0	429,903	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,021,370	0	2,021,370	-295	2,021,075	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	13,912	13,912	0	13,912	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	27,288	27,288	0	27,288	18.00
19.00	Other Health Care Costs	0	56,765	56,765	0	56,765	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	97,965	97,965	0	97,965	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,021,370	97,965	2,119,335	-295	2,119,040	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	295	295	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	295	295	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	19,810	19,810	0	19,810	29.00
30.00	Administrative Costs	262,910	830,933	1,093,843	0	1,093,843	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	262,910	850,743	1,113,653	0	1,113,653	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,284,280	948,708	3,232,988	0	3,232,988	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-8607 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/23/2024 4:01 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	328,312		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	941,269		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	321,591		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	429,903		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,021,075		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	13,912		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	27,288		18.00
19.00	Other Health Care Costs	0	56,765		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	97,965		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,119,040		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	295		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	295		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	19,810		29.00
30.00	Administrative Costs	-349	1,093,494		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-349	1,113,304		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-349	3,232,639		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-8606 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/23/2024 4:01 pm

RHC V | 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	3,692	0	3,692	0	3,692	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	339,230	0	339,230	0	339,230	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	50,620	0	50,620	0	50,620	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	70,901	0	70,901	0	70,901	9.00
10.00	Subtotal (sum of lines 1 through 9)	464,443	0	464,443	0	464,443	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	4,023	4,023	0	4,023	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	40,524	40,524	0	40,524	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	44,547	44,547	0	44,547	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	464,443	44,547	508,990	0	508,990	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	16,287	16,287	0	16,287	29.00
30.00	Administrative Costs	39,683	111,089	150,772	0	150,772	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	39,683	127,376	167,059	0	167,059	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	504,126	171,923	676,049	0	676,049	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 14-8606 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/23/2024 4:01 pm

RHC V | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	3,692		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	339,230		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	50,620		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	70,901		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	464,443		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	4,023		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	40,524		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	44,547		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	508,990		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	16,287		29.00
30.00	Administrative Costs	-1,563	149,209		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,563	165,496		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,563	674,486		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 15-8573 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/23/2024 4:01 pm

RHC VI | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	0	0	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	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	0	0	0	0	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	0	1,423	1,423	0	1,423	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	1,423	1,423	0	1,423	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,423	1,423	0	1,423	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1320 | Component CCN: 15-8573 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/23/2024 4:01 pm

RHC VI | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7.10	Marriage and Family Therapist				7.10
7.11	Mental Health Counselor				7.11
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0		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	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	0		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	1,423		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	1,423		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,423		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320 | Component CCN: 14-3987 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/23/2024 4:01 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	7.08	29,615	4,200	29,736		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	6.61	18,186	2,100	13,881		3.00
4.00	Subtotal (sum of lines 1 through 3)	13.69	47,801		43,617	47,801	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	13.69	47,801			47,801	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)	9,192,635	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	52,671	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	9,245,306	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.994303	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	5,503,926	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	2,062,777	15.00
16.00	Total overhead (sum of lines 14 and 15)	7,566,703	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	7,566,703	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	7,523,595	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	16,716,230	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320 | Component CCN: 14-3989 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/23/2024 4:01 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	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.35	3,942	2,100	2,835		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.35	3,942		2,835	3,942	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.35	3,942			3,942	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)	462,575	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	254	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	462,829	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.999451	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	227,132	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	177,229	15.00
16.00	Total overhead (sum of lines 14 and 15)	404,361	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	404,361	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	404,139	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	866,714	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320 | Component CCN: 14-8596 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/23/2024 4:01 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	0.25	697	4,200	1,050		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.30	1,243	2,100	630		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.55	1,940		1,680	1,940	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.55	1,940			1,940	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)	611,194	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	946	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	612,140	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.998455	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	165,890	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	108,814	15.00
16.00	Total overhead (sum of lines 14 and 15)	274,704	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	274,704	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	274,280	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	885,474	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320 | Component CCN: 14-8607 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/23/2024 4:01 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	0.37	1,252	4,200	1,554		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	4.88	19,155	2,100	10,248		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.25	20,407		11,802	20,407	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.25	20,407			20,407	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	2,119,040	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	295	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	2,119,335	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.999861	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	1,113,304	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,038,924	15.00
16.00	Total overhead (sum of lines 14 and 15)	2,152,228	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	2,152,228	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	2,151,929	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	4,270,969	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1320 | Component CCN: 14-8606 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/23/2024 4:01 pm

RHC V | 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	0.07	211	4,200	294		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.95	6,556	2,100	4,095		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.02	6,767		4,389	6,767	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.02	6,767			6,767	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)	508,990	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)	508,990	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)	165,496	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	179,963	15.00
16.00	Total overhead (sum of lines 14 and 15)	345,459	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	345,459	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	345,459	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	854,449	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1320 Component CCN: 14-3987	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/23/2024 4:01 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)		16,716,230	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		573,655	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		16,142,575	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		47,801	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)		47,801	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		337.70	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	321.40	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	321.40	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	11,079	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	3,560,791	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	313	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	100,598	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	100,598	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	3,661,389	16.00
16.01	Total program charges (see instructions)(from contractor's records)		2,265,441	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		58,286	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		94,200	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.)		2,693,838	16.04
16.05	Total program cost (see instructions)	0	2,788,038	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		199,891	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		398,888	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		2,788,038	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		239,627	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		3,027,665	22.00
23.00	Allowable bad debts (see instructions)		92,521	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		60,139	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		76,045	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)		3,087,804	26.00
26.01	Sequestration adjustment (see instructions)		61,756	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		2,690,829	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)		335,219	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: 14-1320 Component CCN: 14-3989	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/23/2024 4:01 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)		866,714	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		84,328	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		782,386	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,942	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)		3,942	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		198.47	7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	236.66	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	198.47	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	435	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	86,334	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	86,334	16.00
16.01	Total program charges (see instructions)(from contractor's records)		77,014	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,460	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		6,121	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.)		53,476	16.04
16.05	Total program cost (see instructions)	0	59,597	16.05
17.00	Primary payer amounts		32	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		13,368	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		11,598	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		59,565	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		22,825	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		82,390	22.00
23.00	Allowable bad debts (see instructions)		3,524	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		2,291	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		2,600	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)		84,681	26.00
26.01	Sequestration adjustment (see instructions)		1,694	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		50,637	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)		32,350	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: 14-1320 Component CCN: 14-8596	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/23/2024 4:01 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)		885,474	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		62,702	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		822,772	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,940	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)		1,940	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		424.11	7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	371.66	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	371.66	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	455	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	169,105	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	169,105	16.00
16.01	Total program charges (see instructions)(from contractor's records)		77,555	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,540	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		14,260	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.)		114,500	16.04
16.05	Total program cost (see instructions)	0	128,760	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		11,720	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		11,859	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		128,760	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		33,831	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		162,591	22.00
23.00	Allowable bad debts (see instructions)		2,106	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		1,369	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,925	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)		163,960	26.00
26.01	Sequestration adjustment (see instructions)		3,279	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		121,335	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)		39,346	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: 14-1320 Component CCN: 14-8607	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/23/2024 4:01 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)			4,270,969	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			4,305	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			4,266,664	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			20,407	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)			20,407	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			209.08	7.00
		Calculation of Limit (1)			
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	343.44		8.00
9.00	Rate for Program covered visits (see instructions)	0.00	209.08		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,839		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	593,578		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	593,578		16.00
16.01	Total program charges (see instructions)(from contractor's records)		848,642		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		22,218		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		15,540		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.)		422,383		16.04
16.05	Total program cost (see instructions)	0	437,923		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		50,059		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		155,080		19.00
20.00	Net program cost excluding injections/infusions (see instructions)		437,923		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,551		21.00
21.50	Total program IOP OPPS payments (see instructions)				21.50
21.55	Total program IOP Costs (see instructions)				21.55
21.60	Program IOP deductible and coinsurance (see instructions)				21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		440,474		22.00
23.00	Allowable bad debts (see instructions)		14,614		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		9,499		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		10,895		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)		449,973		26.00
26.01	Sequestration adjustment (see instructions)		8,999		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		391,531		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)		49,443		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: 14-1320 Component CCN: 14-8606	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/23/2024 4:01 pm
	Title XVIII	RHC V	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)		854,449	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		854,449	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		6,767	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)		6,767	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		126.27	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2023 through 12/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	132.33	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	126.27	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	628	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	79,298	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	79,298	16.00
16.01	Total program charges (see instructions)(from contractor's records)		103,554	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,322	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,075	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.)		50,006	16.04
16.05	Total program cost (see instructions)	0	54,081	16.05
17.00	Primary payer amounts		230	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		12,715	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		17,033	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		53,851	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
21.50	Total program IOP OPPS payments (see instructions)			21.50
21.55	Total program IOP Costs (see instructions)			21.55
21.60	Program IOP deductible and coinsurance (see instructions)			21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)		53,851	22.00
23.00	Allowable bad debts (see instructions)		1,014	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		659	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		354	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)		54,510	26.00
26.01	Sequestration adjustment (see instructions)		1,090	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		46,143	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)		7,277	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: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4

Component CCN: 14-3987 | Date/Time Prepared: 5/23/2024 4:01 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)	8,796,285	8,796,285	8,796,285	8,796,285	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.004138	0.008622	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	36,399	75,842	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	132,124	71,102	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	168,523	146,944	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	9,192,635	9,192,635	9,192,635	9,192,635	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	7,523,595	7,523,595	7,523,595	7,523,595	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.018332	0.015985	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	137,923	120,265	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	306,446	267,209	0	0	10.00
11.00	Total number of injections/infusions (from your records)	707	1,473	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	433.45	181.40	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	267	683	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)	115,731	123,896	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)		573,655	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)		239,627	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4

Component CCN: 14-3989 | Date/Time Prepared: 5/23/2024 4:01 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)	447,585	447,585	447,585	447,585	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.005461	0.020121	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	2,444	9,006	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	17,193	16,364	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	19,637	25,370	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	462,575	462,575	462,575	462,575	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	404,139	404,139	404,139	404,139	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.042451	0.054845	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	17,156	22,165	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	36,793	47,535	0	0	10.00
11.00	Total number of injections/infusions (from your records)	92	339	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	399.92	140.22	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	15	120	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)	5,999	16,826	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)		84,328	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)		22,825	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4

Component CCN: 14-8596 | Date/Time Prepared: 5/23/2024 4:01 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)	591,358	591,358	591,358	591,358	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.004516	0.037733	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	2,671	22,314	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	5,793	12,502	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	8,464	34,816	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	611,194	611,194	611,194	611,194	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	274,280	274,280	274,280	274,280	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.013848	0.056964	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,798	15,624	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	12,262	50,440	0	0	10.00
11.00	Total number of injections/infusions (from your records)	31	259	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	395.55	194.75	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	23	127	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	9,098	24,733	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)		62,702	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)		33,831	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1320 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4

Component CCN: 14-8607 | Date/Time Prepared: 5/23/2024 4:01 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)	2,021,075	2,021,075	2,021,075	2,021,075	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000412	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	833	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	1,303	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	2,136	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,119,040	2,119,040	2,119,040	2,119,040	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,151,929	2,151,929	2,151,929	2,151,929	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.001008	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	2,169	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	4,305	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	27	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	159.44	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	16	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)	0	2,551	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)		4,305	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)		2,551	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1320 | Component CCN: 15-8573 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/23/2024 4:01 pm

Title XVIII | RHC VI | 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)	0	0	0	0	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000793	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	0	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	965	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	965	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	0	0	0	0	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	0	0	0	0	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.000000	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	0	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	965	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	20	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	48.25	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	10	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)	0	483	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)		965	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)		483	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1320 Component CCN: 14-3987	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/23/2024 4:01 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		2,563,437	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		08/24/2023	127,392	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)		127,392	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		2,690,829	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		335,219	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		3,026,048	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1320 Component CCN: 14-3989	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/23/2024 4:01 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		51,503	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		08/24/2023	866	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)		-866	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		50,637	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		32,350	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		82,987	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1320 Component CCN: 14-8596	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/23/2024 4:01 pm
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		99,530	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		08/24/2023	21,805	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)		21,805	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		121,335	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		39,346	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		160,681	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1320 Component CCN: 14-8607	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/23/2024 4:01 pm
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		423,529	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		08/24/2023	31,998	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)		-31,998	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		391,531	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		49,443	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		440,974	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1320 Component CCN: 14-8606	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/23/2024 4:01 pm
		RHC V	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		46,143	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)		46,143	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		7,277	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		53,420	7.00

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