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: 14-1309	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/29/2024 8:55 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/29/2024 Time: 8:55 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 CARLE EUREKA HOSPITAL (14-1309) 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				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				2
3	Signatory Title				3
4	Date				4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-22,083	-308,962	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER (OTHER)						4.00
5.00	SWING BED - SNF	0	-203,064	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		146,629		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-25,189		0	10.01
10.02	RURAL HEALTH CLINIC (RHC) III	0		-36,177		0	10.02
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	TOTAL	0	-225,147	-223,699	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: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 8:55 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 101 SOUTH MAJOR STREET	PO Box:			1.00
2.00	City: EUREKA	State: IL	Zip Code: 61530	County: WOODFORD	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	CARLE EUREKA HOSPITAL	141309	37900	1	01/01/2001	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	EUREKA SWING BED	14Z309	99914		01/01/2001	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	CARLE EUREKA FAMILY CLINIC	148581	99914		11/29/2017	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	CARLE EL PASO FAMILY CLINIC	148582	99914		11/29/2017	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	CARLE ROANOKE	148620	99914		12/29/2020	N	O	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2023	12/31/2023	20.00
21.00	Type of Control (see instructions)	1		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 8:55 pm

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 8:55 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2024 8:55 pm

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 8:55 pm

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2024 8:55 pm

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

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

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

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

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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	6,034	0	12,843	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	Y	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H077	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: CARLE HEALTH SYSTEM	Contractor's Name: NGS	Contractor's Number: 06101	141.00
142.00	Street: 611 W PARK STREET	PO Box:		142.00
143.00	City: URBANA	State: IL	Zip Code: 61820	143.00

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

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

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					1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	Y	Y	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10
					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.		N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.00	169.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2024 8:55 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)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?		N	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	04/09/2024	Y	04/09/2024	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

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		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.					33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE		LEE		41.00
42.00	Enter the employer/company name of the cost report preparer.	CARLE HEALTH SYSTEM				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	417-268-5953		KYLE.LEE2@CARLE.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 OF FINANCE		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: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 8:55 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	17,068.00	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	17,068.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	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	17,068.00	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	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	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
25.10	CMHC - CORF	99.10				0	25.10
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 (RHC)	88.02				0	26.02
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: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 8:55 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)	337	0	743			1.00
2.00	HMO and other (see instructions)	149	31				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	560	193	753			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		122	122			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	897	315	1,618			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	0			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)	897	315	1,618	0.00	94.12	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	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	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
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC	4,470	0	15,502	0.00	21.00	26.00
26.01	RURAL HEALTH CLINIC II	1,811	0	5,445	0.00	6.24	26.01
26.02	RURAL HEALTH CLINIC (RHC)	149	0	850	0.00	2.89	26.02
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	124.25	27.00
28.00	Observation Bed Days		0	108			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: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2024 8:55 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	97	2	185	1.00
2.00	HMO and other (see instructions)			42	8		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	97	2	185	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	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0		0	0	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
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC (RHC)	0.00					26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1309 | Component CCN: 14-8581 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 8:55 pm

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	105 S MAJOR ST	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	EUREKA	IL	61530	2.00

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

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

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

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

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1309 Component CCN: 14-8581	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/29/2024 8:55 pm
		RHC I	Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		WOODFORD				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	17:30	08:30	17:30	08:30	17:30	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:30	17:30	08:30	14:30		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1309 | Component CCN: 14-8582 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 8:55 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			385 S ORANGE STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	EL PASO		IL	61738	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: 14-1309 Component CCN: 14-8582	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/29/2024 8:55 pm
		RHC II	Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		WOODFORD				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	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:30	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1309 | Component CCN: 14-8620 | Period: From 01/01/2023 To 12/31/2023 | Worksheet S-8 | Date/Time Prepared: 5/29/2024 8:55 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			415 WEST FRONT STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ROANOKE		IL	61561	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	05:00	07:00	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: 14-1309 Component CCN: 14-8620	Period: From 01/01/2023 To 12/31/2023	Worksheet S-8 Date/Time Prepared: 5/29/2024 8:55 pm
		RHC III	Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		WOODFORD				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	05:00			07:00	05:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	05:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1309	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 8:55 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)	0.589805	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,992,302	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	5,994,262	6.00
7.00	Medicaid cost (line 1 times line 6)	3,535,446	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	1,543,144	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)	1,543,144	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)	122,699	107,505	230,204	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	72,368	82,927	155,295	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)	72,368	82,927	155,295	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)	59,918	25.01
26.00	Bad debt amount (see instructions)	834,410	26.00
27.00	Medicare reimbursable bad debts (see instructions)	43,374	27.00
27.01	Medicare allowable bad debts (see instructions)	66,730	27.01
28.00	Non-Medicare bad debt amount (see instructions)	767,680	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	476,138	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	631,433	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,174,577	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1309	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/29/2024 8:55 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: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 8:55 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	-228,584	-228,584	1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION		0	0	183,189	183,189	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	351,275	128,042	479,317	670,241	1,149,558	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	407,621	4,952,686	5,360,307	-117,504	5,242,803	5.02
7.00	00700	OPERATION OF PLANT	304,580	269,350	573,930	263,709	837,639	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	179,277	154,541	333,818	-15,468	318,350	9.00
10.00	01000	DIETARY	187,200	127,482	314,682	-30,564	284,118	10.00
13.00	01300	NURSING ADMINISTRATION	328,922	121,935	450,857	-3,660	447,197	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	41,609	41,241	82,850	-13	82,837	14.00
15.00	01500	PHARMACY	265,405	1,225,239	1,490,644	-423,678	1,066,966	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,303,360	699,757	2,003,117	-172,767	1,830,350	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	634,527	799,253	1,433,780	-476,931	956,849	50.00
53.00	05300	ANESTHESIOLOGY	391,759	67,355	459,114	-20,630	438,484	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	690,318	607,043	1,297,361	-44,676	1,252,685	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	705,258	994,346	1,699,604	-15,648	1,683,956	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	87,185	70,288	157,473	-11,116	146,357	65.00
66.00	06600	PHYSICAL THERAPY	497,616	145,934	643,550	-27,034	616,516	66.00
67.00	06700	OCCUPATIONAL THERAPY	123,256	38,093	161,349	0	161,349	67.00
68.00	06800	SPEECH PATHOLOGY	18,600	31,413	50,013	-26,688	23,325	68.00
69.00	06900	ELECTROCARDIOLOGY	229,580	55,661	285,241	-12,369	272,872	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	223,988	223,988	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	169,033	169,033	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	466,943	466,943	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,647,996	1,008,555	3,656,551	-149,918	3,506,633	88.00
88.01	08801	RURAL HEALTH CLINIC II	772,987	382,853	1,155,840	-64,393	1,091,447	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	235,157	86,614	321,771	6,192	327,963	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	112,589	487,427	600,016	-35,464	564,552	90.00
91.00	09100	EMERGENCY	3,182,197	536,443	3,718,640	-106,190	3,612,450	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,698,274	13,031,551	26,729,825	0	26,729,825	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0	194.02
194.03	07953	EDUCATION	0	0	0	0	0	194.03
194.04	07954	SCHOOL THERAPY	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	13,698,274	13,031,551	26,729,825	0	26,729,825	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A | Date/Time Prepared: 5/29/2024 8:55 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	461,363	232,779		1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION	0	183,189		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	405,720	405,720		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	-475,689	673,869		5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	1,291,246	6,534,049		5.02
7.00	00700	OPERATION OF PLANT	946,823	1,784,462		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		8.00
9.00	00900	HOUSEKEEPING	0	318,350		9.00
10.00	01000	DIETARY	-659	283,459		10.00
13.00	01300	NURSING ADMINISTRATION	582,430	1,029,627		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	321,541	404,378		14.00
15.00	01500	PHARMACY	7,867	1,074,833		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,830,350		30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0		33.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	956,849		50.00
53.00	05300	ANESTHESIOLOGY	0	438,484		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,252,685		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	1,683,956		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	146,357		65.00
66.00	06600	PHYSICAL THERAPY	0	616,516		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	161,349		67.00
68.00	06800	SPEECH PATHOLOGY	0	23,325		68.00
69.00	06900	ELECTROCARDIOLOGY	-7,980	264,892		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	223,988		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	169,033		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	466,943		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	3,506,633		88.00
88.01	08801	RURAL HEALTH CLINIC II	-12	1,091,435		88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	-352	327,611		88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	-410,828	153,724		90.00
91.00	09100	EMERGENCY	-1,170,352	2,442,098		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
		SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0		111.00
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,951,118	28,680,943		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0		194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0		194.01
194.02	07952	RENTAL PROPERTIES	0	0		194.02
194.03	07953	EDUCATION	0	0		194.03
194.04	07954	SCHOOL THERAPY	0	0		194.04
194.05	07955	VACANT SPACE	0	0		194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	1,951,118	28,680,943		200.00

RECLASSIFICATIONS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 8:55 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	466,943	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
	TOTALS		0	466,943	
	B - CRNA RECLASS				
1.00			0	0	1.00
			0	0	
	C - RECLASS MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	223,988	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	169,033	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
	TOTALS		0	393,021	
	D - INTERNAL RENT				
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	1,166,208	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
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	TOTALS		0	1,166,208	
	E - BUILDING DEPRECIATION				
1.00	NEW 2016 BUILDING & FIXT ADDITION	1.01	0	186,485	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	186,485	
	F - HOME OFFICE UTILITIES				
1.00	OPERATION OF PLANT	7.00	0	444,153	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	8,146	2.00
3.00	RURAL HEALTH CLINIC II	88.01	0	19,896	3.00
4.00	RURAL HEALTH CLINIC (RHC)	88.02	0	6,192	4.00
	TOTALS		0	478,387	
	K - EL PASO RHC BUILDING DEPRECIATION				
1.00	RURAL HEALTH CLINIC II	88.01	0	45,395	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	45,395	
500.00	Grand Total: Increases		0	2,736,439	500.00

RECLASSIFICATIONS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-6 | Date/Time Prepared: 5/29/2024 8:55 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	421,974	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	327	0		2.00
3.00	OPERATING ROOM	50.00	0	195	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	1,660	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	191	0		5.00
6.00	ELECTROCARDIOLOGY	69.00	0	7,209	0		6.00
7.00	CLINIC	90.00	0	35,102	0		7.00
8.00	EMERGENCY	91.00	0	285	0		8.00
	TOTALS		0	466,943			
	B - CRNA RECLASS						
1.00			0	0			1.00
			0	0			
	C - RECLASS MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	13	0		1.00
2.00	OPERATING ROOM	50.00	0	152,795	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	16,394	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	227	0		4.00
5.00	CLINIC	90.00	0	362	0		5.00
6.00	EMERGENCY	91.00	0	54,197	0		6.00
7.00	OPERATING ROOM	50.00	0	169,033	0		7.00
	TOTALS		0	393,021			
	D - INTERNAL RENT						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	17,580	0		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	117,504	0		2.00
3.00	OPERATION OF PLANT	7.00	0	180,444	0		3.00
4.00	HOUSEKEEPING	9.00	0	15,468	0		4.00
5.00	DIETARY	10.00	0	30,564	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	3,660	0		6.00
7.00	PHARMACY	15.00	0	1,704	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	172,440	0		8.00
9.00	OPERATING ROOM	50.00	0	154,908	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	4,236	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	44,676	0		11.00
12.00	LABORATORY	60.00	0	15,648	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	9,456	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	26,616	0		14.00
15.00	SPEECH PATHOLOGY	68.00	0	26,688	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	5,160	0		16.00
17.00	RURAL HEALTH CLINIC	88.00	0	158,064	0		17.00
18.00	RURAL HEALTH CLINIC II	88.01	0	129,684	0		18.00
19.00	EMERGENCY	91.00	0	51,708	0		19.00
	TOTALS		0	1,166,208			
	E - BUILDING DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	186,485	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	186,485			
	F - HOME OFFICE UTILITIES						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	478,387	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	478,387			
	K - EL PASO RHC BUILDING DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	42,099	9		1.00
2.00	NEW 2016 BUILDING & FIXT ADDITION	1.01	0	3,296	9		2.00
	TOTALS		0	45,395			
500.00	Grand Total: Decreases		0	2,736,439			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2024 8:55 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	380,000	0	0	0	0	1.00
2.00	Land Improvements	1,550,399	15,909	0	15,909	0	2.00
3.00	Buildings and Fixtures	22,115,988	82,806	0	82,806	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	5,612,347	766,595	0	766,595	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,658,734	865,310	0	865,310	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	29,658,734	865,310	0	865,310	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	380,000	0	1.00
2.00	Land Improvements	1,566,308	0	2.00
3.00	Buildings and Fixtures	22,198,794	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	6,378,942	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	30,524,044	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	30,524,044	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2024 8:55 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	NEW 2016 BUILDING & FIXT ADDITION	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	NEW 2016 BUILDING & FIXT ADDITION	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 5/29/2024 8:55 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	CAP REL COSTS-BLDG & FIXT	475,213	0	475,213	0.043943	0	1.00
1.01	NEW 2016 BUILDING & FIXT ADDITION	7,123,792	0	7,123,792	0.658743	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	3,215,214	0	3,215,214	0.297314	0	2.00
3.00	Total (sum of lines 1-2)	10,814,219	0	10,814,219	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	CAP REL COSTS-BLDG & FIXT	0	0	0	232,779	0	1.00
1.01	NEW 2016 BUILDING & FIXT ADDITION	0	0	0	183,189	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	415,968	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	232,779	1.00
1.01	NEW 2016 BUILDING & FIXT ADDITION	0	0	0	0	183,189	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	415,968	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 8:55 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW 2016 BUILDING & FIXT ADDITION (chapter 2)		0	NEW 2016 BUILDING & FIXT ADDITION	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-1,576,180			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	4,038,687			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-659	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW 2016 BUILDING & FIXT ADDITION		0	NEW 2016 BUILDING & FIXT ADDITION	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8 | Date/Time Prepared: 5/29/2024 8:55 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER OPERATING REVENUE	B	-21,130	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.00
33.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.01
33.02	OTHER OPERATING REVENUE	B	-5,000	EMERGENCY	91.00	0	33.02
33.03	OTHER OPERATING REVENUE	B	-7,980	ELECTROCARDIOLOGY	69.00	0	33.03
33.04	OTHER OPERATING REVENUE	B	-589	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.04
33.05	OTHER OPERATING REVENUE		0		0.00	0	33.05
33.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.06
33.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.07
33.08	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.08
33.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.09
33.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.10
33.11	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.11
33.12	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.12
33.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.13
33.14	ADVERTISING	A	-567	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.14
33.15	IDPA TAX ASSESSMENT	A	-475,100	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.15
33.16	ADVERTISING	A	-12	RURAL HEALTH CLINIC II	88.01	9	33.16
33.17	ADVERTISING	A	-352	RURAL HEALTH CLINIC (RHC)	88.02	0	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.18
33.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.19
33.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.20
33.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.21
33.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.22
33.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.23
33.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.24
33.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.25
33.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.26
33.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.27
33.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.28
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,951,118				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2024 8:55 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	7.00	OPERATION OF PLANT	MAINTENANCE	946,823	0	1.00
2.00	13.00	NURSING ADMINISTRATION	PATIENT CARE	582,430	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EH&W	405,720	0	3.00
4.00	14.00	CENTRAL SERVICES & SUPPLY	SPD	321,541	0	4.00
4.03	5.02	OTHER ADMINISTRATIVE AND GEN	A&G	6,000,443	4,458,067	4.03
4.04	5.02	OTHER ADMINISTRATIVE AND GEN	INTERNAL RENT	936,775	1,166,208	4.04
4.05	15.00	PHARMACY	349B	7,867	0	4.05
4.06	1.00	CAP REL COSTS-BLDG & FIXT	DEPRECIATION	461,363	0	4.06
4.07	0.00			0	0	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,662,962	5,624,275	5.00

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

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

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

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

6.00	B		0.00	ADVOCATE HEALTH	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-1309	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8-1 Date/Time Prepared: 5/29/2024 8:55 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	946,823	9		1.00
2.00	582,430	9		2.00
3.00	405,720	9		3.00
4.00	321,541	0		4.00
4.03	1,542,376	0		4.03
4.04	-229,433	0		4.04
4.05	7,867	0		4.05
4.06	461,363	9		4.06
4.07	0	0		4.07
5.00	4,038,687			5.00

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

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

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

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

6.00	HEALTHCARE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2024 8:55 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	0.00		0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	1,856,426	1,165,352	691,074	0	0	2.00
3.00	90.00	CLINIC	410,828	410,828	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,267,254	1,576,180	691,074		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	0.00		0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	0.00		0	0	0	0		1.00
2.00	91.00	EMERGENCY	0	0	0	1,165,352		2.00
3.00	90.00	CLINIC	0	0	0	410,828		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,576,180		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 8:55 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	NEW 2016 BUILDING & FIXT ADDITION	MVBLE EQUIP		
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	232,779	232,779				1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION	183,189	0	183,189			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0			0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	405,720	0	0	0	405,720	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	673,869	40,565	0	0	10,404	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	6,534,049	24,212	3,885	0	12,073	5.02
7.00	00700	OPERATION OF PLANT	1,784,462	28,448	30,708	0	9,021	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,156	0	0	0	8.00
9.00	00900	HOUSEKEEPING	318,350	3,391	717	0	5,310	9.00
10.00	01000	DIETARY	283,459	6,690	0	0	5,544	10.00
13.00	01300	NURSING ADMINISTRATION	1,029,627	801	0	0	9,742	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	404,378	0	0	0	1,232	14.00
15.00	01500	PHARMACY	1,074,833	0	0	0	7,861	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,700	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,830,350	9,657	71,902	0	38,603	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	956,849	5,123	72,476	0	18,793	50.00
53.00	05300	ANESTHESIOLOGY	438,484	1,964	0	0	11,603	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,252,685	7,958	2,152	0	20,446	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,683,956	3,010	0	0	20,888	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	146,357	546	0	0	2,582	65.00
66.00	06600	PHYSICAL THERAPY	616,516	5,819	0	0	14,738	66.00
67.00	06700	OCCUPATIONAL THERAPY	161,349	4,425	0	0	3,651	67.00
68.00	06800	SPEECH PATHOLOGY	23,325	5,842	0	0	551	68.00
69.00	06900	ELECTROCARDIOLOGY	264,892	1,129	0	0	6,800	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	223,988	341	1,349	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	169,033	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	466,943	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,506,633	34,360	0	0	78,428	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,091,435	29,521	0	0	22,894	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	327,611	0	0	0	6,965	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	153,724	0	0	0	3,335	90.00
91.00	09100	EMERGENCY	2,442,098	11,121	0	0	94,256	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,680,943	232,779	183,189	0	405,720	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0	194.02
194.03	07953	EDUCATION	0	0	0	0	0	194.03
194.04	07954	SCHOOL THERAPY	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I Date/Time Prepared: 5/29/2024 8:55 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	NEW 2016 BUILDING & FIXT ADDITION	MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
202.00	TOTAL (sum lines 118 through 201)	28,680,943	232,779	183,189	0	405,720	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 8:55 pm

		Cost Center Description	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	
			4A	5.01	5A.01	5.02	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	724,838	724,838				5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	6,574,219	205,457	6,779,676	6,779,676		5.02
7.00	00700	OPERATION OF PLANT	1,852,639	57,901	1,910,540	591,419	2,501,959	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,156	67	2,223	688	47,202	8.00
9.00	00900	HOUSEKEEPING	327,768	10,244	338,012	104,634	65,762	9.00
10.00	01000	DIETARY	295,693	9,241	304,934	94,394	129,725	10.00
13.00	01300	NURSING ADMINISTRATION	1,040,170	32,508	1,072,678	332,054	15,541	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	405,610	12,677	418,287	129,483	0	14.00
15.00	01500	PHARMACY	1,082,694	33,837	1,116,531	345,629	7,257	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,700	178	5,878	1,820	110,523	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,950,512	60,959	2,011,471	622,663	740,331	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,053,241	32,917	1,086,158	336,227	644,387	50.00
53.00	05300	ANESTHESIOLOGY	452,051	14,128	466,179	144,309	38,083	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,283,241	40,105	1,323,346	409,650	170,505	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,707,854	53,376	1,761,230	545,199	58,376	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	149,485	4,672	154,157	47,720	10,596	65.00
66.00	06600	PHYSICAL THERAPY	637,073	19,910	656,983	203,373	112,835	66.00
67.00	06700	OCCUPATIONAL THERAPY	169,425	5,295	174,720	54,086	113,285	67.00
68.00	06800	SPEECH PATHOLOGY	29,718	929	30,647	9,487	0	68.00
69.00	06900	ELECTROCARDIOLOGY	272,821	8,526	281,347	87,093	21,899	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	225,678	7,053	232,731	72,043	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	169,033	5,283	174,316	53,961	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	466,943	14,593	481,536	149,062	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,619,421	0	3,619,421	1,120,419	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,143,850	0	1,143,850	354,086	0	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	334,576	10,457	345,033	106,807	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	157,059	4,909	161,968	50,138	0	90.00
91.00	09100	EMERGENCY	2,547,475	79,616	2,627,091	813,232	215,652	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0			92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,680,943	724,838	28,680,943	6,779,676	2,501,959	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0	194.02
194.03	07953	EDUCATION	0	0	0	0	0	194.03
194.04	07954	SCHOOL THERAPY	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments	0		0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	28,680,943	724,838	28,680,943	6,779,676	2,501,959	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 8:55 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			8.00	9.00	10.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	50,113					8.00
9.00	00900	HOUSEKEEPING	0	508,408				9.00
10.00	01000	DIETARY	0	10,992	540,045			10.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,420,273		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,814	0	0	559,584	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,386	119,988	540,045	589,946	0	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,911	73,246	0	241,962	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,386	36,777	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	16,745	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	17,464	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,719	39,140	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	686	3,185	0	66,054	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	319,056	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	240,485	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	493	43,865	0	21,917	0	90.00
91.00	09100	EMERGENCY	19,532	135,192	0	500,260	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,113	508,408	540,045	1,420,139	559,541	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0	194.02
194.03	07953	EDUCATION	0	0	0	134	43	194.03
194.04	07954	SCHOOL THERAPY	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	50,113	508,408	540,045	1,420,273	559,584	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 8:55 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						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
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,469,417					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	118,221				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	118,221	0	0	4,758,051	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	2,387,891	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	648,571	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	1,946,664	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	2,381,550	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	229,937	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	1,014,050	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	342,091	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	40,134	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	460,264	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	623,830	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	468,762	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,469,417	0	0	0	2,100,015	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	4,739,840	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	1,497,936	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	0	0	0	0	451,840	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	278,381	90.00
91.00	09100	EMERGENCY	0	0	0	0	4,310,959	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,469,417	118,221	0	0	28,680,766	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0	194.02
194.03	07953	EDUCATION	0	0	0	0	177	194.03
194.04	07954	SCHOOL THERAPY	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,469,417	118,221	0	0	28,680,943	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part I | Date/Time Prepared: 5/29/2024 8:55 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL				5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL				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
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	4,758,051		30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0		33.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,387,891		50.00
53.00	05300	ANESTHESIOLOGY	0	648,571		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,946,664		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	2,381,550		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	229,937		65.00
66.00	06600	PHYSICAL THERAPY	0	1,014,050		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	342,091		67.00
68.00	06800	SPEECH PATHOLOGY	0	40,134		68.00
69.00	06900	ELECTROCARDIOLOGY	0	460,264		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	623,830		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	468,762		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,100,015		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	4,739,840		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,497,936		88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	0	451,840		88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	278,381		90.00
91.00	09100	EMERGENCY	0	4,310,959		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
		SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0		111.00
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	28,680,766		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0		194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0		194.01
194.02	07952	RENTAL PROPERTIES	0	0		194.02
194.03	07953	EDUCATION	0	177		194.03
194.04	07954	SCHOOL THERAPY	0	0		194.04
194.05	07955	VACANT SPACE	0	0		194.05
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	28,680,943		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 8:55 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS NEW 2016 BUILDING & FIXT ADDITION	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	0	40,565	0	0	40,565	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	0	24,212	3,885	0	28,097	5.02
7.00	00700	OPERATION OF PLANT	700	28,448	30,708	0	59,856	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,156	0	0	2,156	8.00
9.00	00900	HOUSEKEEPING	0	3,391	717	0	4,108	9.00
10.00	01000	DIETARY	0	6,690	0	0	6,690	10.00
13.00	01300	NURSING ADMINISTRATION	0	801	0	0	801	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,266	5,700	0	0	14,966	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,223	9,657	71,902	0	85,782	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,123	72,476	0	77,599	50.00
53.00	05300	ANESTHESIOLOGY	0	1,964	0	0	1,964	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	108,333	7,958	2,152	0	118,443	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	3,010	0	0	3,010	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	546	0	0	546	65.00
66.00	06600	PHYSICAL THERAPY	0	5,819	0	0	5,819	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,425	0	0	4,425	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,842	0	0	5,842	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,129	0	0	1,129	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	341	1,349	0	1,690	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	216,714	34,360	0	0	251,074	88.00
88.01	08801	RURAL HEALTH CLINIC II	8,854	29,521	0	0	38,375	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	11,121	0	0	11,121	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	348,090	232,779	183,189	0	764,058	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0	194.02
194.03	07953	EDUCATION	0	0	0	0	0	194.03
194.04	07954	SCHOOL THERAPY	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	348,090	232,779	183,189	0	764,058	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 8:55 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	OTHER ADMINISTRATIVE AND GENERAL	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	5.01	5.02	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	0	40,565				5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	0	11,500	39,597			5.02
7.00	00700	OPERATION OF PLANT	0	3,240	3,454	66,550		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4	4	1,256	3,420	8.00
9.00	00900	HOUSEKEEPING	0	573	611	1,749	0	9.00
10.00	01000	DIETARY	0	517	551	3,451	0	10.00
13.00	01300	NURSING ADMINISTRATION	0	1,819	1,939	413	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	709	756	0	0	14.00
15.00	01500	PHARMACY	0	1,894	2,019	193	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10	11	2,940	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,411	3,637	19,693	1,050	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,842	1,964	17,140	403	50.00
53.00	05300	ANESTHESIOLOGY	0	791	843	1,013	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,244	2,393	4,535	436	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	2,987	3,184	1,553	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	261	279	282	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,114	1,188	3,001	117	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	296	316	3,013	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	52	55	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	477	509	582	47	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	395	421	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	296	315	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	817	871	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	6,542	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	2,068	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	0	585	624	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	275	293	0	34	90.00
91.00	09100	EMERGENCY	0	4,456	4,750	5,736	1,333	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	40,565	39,597	66,550	3,420	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0	194.02
194.03	07953	EDUCATION	0	0	0	0	0	194.03
194.04	07954	SCHOOL THERAPY	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	0	40,565	39,597	66,550	3,420	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II | Date/Time Prepared: 5/29/2024 8:55 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			9.00	10.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	7,041					9.00
10.00	01000	DIETARY	152	11,361				10.00
13.00	01300	NURSING ADMINISTRATION	0	0	4,972			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	164	0	0	1,629		14.00
15.00	01500	PHARMACY	0	0	0	0	4,106	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,662	11,361	2,066	0	0	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,014	0	847	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	509	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	232	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	242	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	542	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	44	0	231	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	929	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	700	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,106	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	607	0	77	0	0	90.00
91.00	09100	EMERGENCY	1,873	0	1,751	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,041	11,361	4,972	1,629	4,106	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0	194.02
194.03	07953	EDUCATION	0	0	0	0	0	194.03
194.04	07954	SCHOOL THERAPY	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	7,041	11,361	4,972	1,629	4,106	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 8:55 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						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
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,927					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,927	0		146,589	0	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0		0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0		0	0	41.00
42.00	04200	SUBPROVIDER	0	0		0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		100,809	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0		4,611	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		128,560	0	54.00
57.00	05700	CT SCAN	0	0		0	0	57.00
58.00	05800	MRI	0	0		0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		0	0	59.00
60.00	06000	LABORATORY	0	0		10,966	0	60.00
60.01	06001	BLOOD LABORATORY	0	0		0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0		0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0		1,610	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0		11,781	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		8,050	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0		5,949	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		3,019	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		3,435	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		1,311	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		5,794	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		257,616	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		40,443	0	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	0	0		1,209	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89.00
90.00	09000	CLINIC	0	0		1,286	0	90.00
91.00	09100	EMERGENCY	0	0		31,020	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0		0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0		0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0		0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,927	0	0	764,058	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		0	0	190.00
191.00	19100	RESEARCH	0	0		0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		0	0	192.00
193.00	19300	NONPAID WORKERS	0	0		0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0		0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0		0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0		0	0	194.02
194.03	07953	EDUCATION	0	0		0	0	194.03
194.04	07954	SCHOOL THERAPY	0	0		0	0	194.04
194.05	07955	VACANT SPACE	0	0		0	0	194.05
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,927	0	0	764,058	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B Part II Date/Time Prepared: 5/29/2024 8:55 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL			5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL			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
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	146,589		30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		33.00
41.00	04100	SUBPROVIDER - IRF	0		41.00
42.00	04200	SUBPROVIDER	0		42.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	100,809		50.00
53.00	05300	ANESTHESIOLOGY	4,611		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	128,560		54.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MRI	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0		59.00
60.00	06000	LABORATORY	10,966		60.00
60.01	06001	BLOOD LABORATORY	0		60.01
64.00	06400	INTRAVENOUS THERAPY	0		64.00
65.00	06500	RESPIRATORY THERAPY	1,610		65.00
66.00	06600	PHYSICAL THERAPY	11,781		66.00
67.00	06700	OCCUPATIONAL THERAPY	8,050		67.00
68.00	06800	SPEECH PATHOLOGY	5,949		68.00
69.00	06900	ELECTROCARDIOLOGY	3,019		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,435		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,311		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,794		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	257,616		88.00
88.01	08801	RURAL HEALTH CLINIC II	40,443		88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	1,209		88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		89.00
90.00	09000	CLINIC	1,286		90.00
91.00	09100	EMERGENCY	31,020		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	0		99.10
		SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0		110.00
111.00	11100	ISLET ACQUISITION	0		111.00
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	764,058		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0		194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0		194.01
194.02	07952	RENTAL PROPERTIES	0		194.02
194.03	07953	EDUCATION	0		194.03
194.04	07954	SCHOOL THERAPY	0		194.04
194.05	07955	VACANT SPACE	0		194.05
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	764,058		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 8:55 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW 2016 BUILDING & FIXT ADDITION (NEW BUILDI NG SQUARE)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	70,288					1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION	0	21,452				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	13,698,274		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	12,248	0	0	351,275	-724,838	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	7,311	455	0	407,621	0	5.02
7.00	00700	OPERATION OF PLANT	8,590	3,596	0	304,580	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	651	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,024	84	0	179,277	0	9.00
10.00	01000	DIETARY	2,020	0	0	187,200	0	10.00
13.00	01300	NURSING ADMINISTRATION	242	0	0	328,922	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	41,609	0	14.00
15.00	01500	PHARMACY	0	0	0	265,405	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,721	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,916	8,420	0	1,303,360	0	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,547	8,487	0	634,527	0	50.00
53.00	05300	ANESTHESIOLOGY	593	0	0	391,759	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,403	252	0	690,318	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	909	0	0	705,258	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	165	0	0	87,185	0	65.00
66.00	06600	PHYSICAL THERAPY	1,757	0	0	497,616	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,336	0	0	123,256	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,764	0	0	18,600	0	68.00
69.00	06900	ELECTROCARDIOLOGY	341	0	0	229,580	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	103	158	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,375	0	0	2,647,996	-3,619,421	88.00
88.01	08801	RURAL HEALTH CLINIC II	8,914	0	0	772,987	-1,143,850	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	0	0	0	235,157	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	112,589	0	90.00
91.00	09100	EMERGENCY	3,358	0	0	3,182,197	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,288	21,452	0	13,698,274	-5,488,109	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0	194.02
194.03	07953	EDUCATION	0	0	0	0	0	194.03
194.04	07954	SCHOOL THERAPY	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 8:55 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW 2016 BUILDING & FIXT ADDITION (NEW BUILDI NG SQUARE)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A.01	
202.00		Cost to be allocated (per Wkst. B, Part I)	232,779	183,189	0	405,720		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.311789	8.539483	0.000000	0.029618		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 8:55 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5.01	5A.02	5.02	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	23,192,834					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	6,574,219	-6,779,676	21,901,267			5.02
7.00	00700	OPERATION OF PLANT	1,852,639	0	1,910,540	38,959		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,156	0	2,223	735	34,488	8.00
9.00	00900	HOUSEKEEPING	327,768	0	338,012	1,024	0	9.00
10.00	01000	DIETARY	295,693	0	304,934	2,020	0	10.00
13.00	01300	NURSING ADMINISTRATION	1,040,170	0	1,072,678	242	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	405,610	0	418,287	0	0	14.00
15.00	01500	PHARMACY	1,082,694	0	1,116,531	113	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,700	0	5,878	1,721	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,950,512	0	2,011,471	11,528	10,589	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,053,241	0	1,086,158	10,034	4,068	50.00
53.00	05300	ANESTHESIOLOGY	452,051	0	466,179	593	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,283,241	0	1,323,346	2,655	4,395	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,707,854	0	1,761,230	909	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	149,485	0	154,157	165	0	65.00
66.00	06600	PHYSICAL THERAPY	637,073	0	656,983	1,757	1,183	66.00
67.00	06700	OCCUPATIONAL THERAPY	169,425	0	174,720	1,764	0	67.00
68.00	06800	SPEECH PATHOLOGY	29,718	0	30,647	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	272,821	0	281,347	341	472	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	225,678	0	232,731	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	169,033	0	174,316	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	466,943	0	481,536	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	3,619,421	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	1,143,850	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	334,576	0	345,033	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	157,059	0	161,968	0	339	90.00
91.00	09100	EMERGENCY	2,547,475	0	2,627,091	3,358	13,442	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,192,834	-6,779,676	21,901,267	38,959	34,488	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0	194.02
194.03	07953	EDUCATION	0	0	0	0	0	194.03
194.04	07954	SCHOOL THERAPY	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	724,838		6,779,676	2,501,959	50,113	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.031253		0.309556	64.220309	1.453056	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 8:55 pm

	Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5.01	5A.02	5.02	7.00	8.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	40,565		39,597	66,550	3,420	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.001749		0.001808	1.708206	0.099165	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: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 8:55 pm

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (HOURS OF SERVICE)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UISI)	PHARMACY (COSTED REQ UISI)	
			9.00	10.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	4,949					9.00
10.00	01000	DIETARY	107	100				10.00
13.00	01300	NURSING ADMINISTRATION	0	0	42,251			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	115	0	0	393,323		14.00
15.00	01500	PHARMACY	0	0	0	0	466,658	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,168	100	17,550	0	0	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	713	0	7,198	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	358	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	163	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	170	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	381	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	31	0	1,965	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	224,260	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	169,033	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	466,658	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	427	0	652	0	0	90.00
91.00	09100	EMERGENCY	1,316	0	14,882	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,949	100	42,247	393,293	466,658	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0	194.02
194.03	07953	EDUCATION	0	0	4	30	0	194.03
194.04	07954	SCHOOL THERAPY	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	508,408	540,045	1,420,273	559,584	1,469,417	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 8:55 pm

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (HOURS OF SERVICE)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UISI)	PHARMACY (COSTED REQ UISI)	
			9.00	10.00	13.00	14.00	15.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	102.729440	5,400.450000	33.615133	1.422709	3.148809	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,041	11,361	4,972	1,629	4,106	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.422712	113.610000	0.117678	0.004142	0.008799	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: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 8:55 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW 2016 BUILDING & FIXT ADDITION					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL					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
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	200				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	200	0	0		30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0		33.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	0	0	0		88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	0		99.10
		SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	200	0	0		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0		194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0		194.01
194.02	07952	RENTAL PROPERTIES	0	0	0		194.02
194.03	07953	EDUCATION	0	0	0		194.03
194.04	07954	SCHOOL THERAPY	0	0	0		194.04
194.05	07955	VACANT SPACE	0	0	0		194.05
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)	118,221	0	0		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet B-1 | Date/Time Prepared: 5/29/2024 8:55 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	17.00	19.00		
203.00		Unit cost multiplier (Wkst. B, Part I)	591.105000	0.000000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	17,927	0	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	89.635000	0.000000	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 8:55 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,758,051		4,758,051	0	0	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,387,891		2,387,891	0	0	50.00
53.00	05300	ANESTHESIOLOGY	648,571		648,571	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,946,664		1,946,664	0	0	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	2,381,550		2,381,550	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	229,937	0	229,937	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,014,050	0	1,014,050	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	342,091	0	342,091	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	40,134	0	40,134	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	460,264		460,264	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	623,830		623,830	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	468,762		468,762	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,100,015		2,100,015	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,739,840		4,739,840	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,497,936		1,497,936	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	451,840		451,840	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	278,381		278,381	0	0	90.00
91.00	09100	EMERGENCY	4,310,959		4,310,959	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	319,061		319,061		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	28,999,827	0	28,999,827	0	0	200.00
201.00		Less Observation Beds	319,061		319,061		0	201.00
202.00		Total (see instructions)	28,680,766	0	28,680,766	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 8:55 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	1,925,833		1,925,833			30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,265	1,100,788	1,113,053	2.145352	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	19,594	618,372	637,966	1.016623	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	997,137	11,306,229	12,303,366	0.158222	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	828,265	7,351,544	8,179,809	0.291150	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,034	754,377	756,411	0.303984	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	304,923	1,032,104	1,337,027	0.758436	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,561	288,109	340,670	1.004171	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	4,110	628	4,738	8.470663	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	69,718	1,115,985	1,185,703	0.388178	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	42,543	359,719	402,262	1.550805	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	136,157	388,122	524,279	0.894108	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,522,368	2,759,099	4,281,467	0.490490	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,187,188	6,187,188			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,619,391	1,619,391			88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	0	239,986	239,986			88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	1,151	340,373	341,524	0.815114	0.000000	90.00
91.00	09100	EMERGENCY	368,010	6,368,706	6,736,716	0.639920	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	266,992	243,168	510,160	0.625414	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,553,661	42,073,888	48,627,549			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,553,661	42,073,888	48,627,549			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 8:55 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
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
		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
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		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 (RHC)			88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
		SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
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: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 8:55 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	4,758,051		4,758,051	0	4,758,051	30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,387,891		2,387,891	0	2,387,891	50.00
53.00	05300	ANESTHESIOLOGY	648,571		648,571	0	648,571	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,946,664		1,946,664	0	1,946,664	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	2,381,550		2,381,550	0	2,381,550	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	229,937	0	229,937	0	229,937	65.00
66.00	06600	PHYSICAL THERAPY	1,014,050	0	1,014,050	0	1,014,050	66.00
67.00	06700	OCCUPATIONAL THERAPY	342,091	0	342,091	0	342,091	67.00
68.00	06800	SPEECH PATHOLOGY	40,134	0	40,134	0	40,134	68.00
69.00	06900	ELECTROCARDIOLOGY	460,264		460,264	0	460,264	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	623,830		623,830	0	623,830	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	468,762		468,762	0	468,762	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,100,015		2,100,015	0	2,100,015	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,739,840		4,739,840	0	4,739,840	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,497,936		1,497,936	0	1,497,936	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	451,840		451,840	0	451,840	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	278,381		278,381	0	278,381	90.00
91.00	09100	EMERGENCY	4,310,959		4,310,959	0	4,310,959	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	319,061		319,061		319,061	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	28,999,827	0	28,999,827	0	28,999,827	200.00
201.00		Less Observation Beds	319,061		319,061		319,061	201.00
202.00		Total (see instructions)	28,680,766	0	28,680,766	0	28,680,766	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 8:55 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	1,925,833		1,925,833			30.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,265	1,100,788	1,113,053	2.145352	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	19,594	618,372	637,966	1.016623	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	997,137	11,306,229	12,303,366	0.158222	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	828,265	7,351,544	8,179,809	0.291150	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,034	754,377	756,411	0.303984	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	304,923	1,032,104	1,337,027	0.758436	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,561	288,109	340,670	1.004171	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	4,110	628	4,738	8.470663	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	69,718	1,115,985	1,185,703	0.388178	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	42,543	359,719	402,262	1.550805	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	136,157	388,122	524,279	0.894108	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,522,368	2,759,099	4,281,467	0.490490	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,187,188	6,187,188	0.766073	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,619,391	1,619,391	0.925000	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	0	239,986	239,986	1.882776	0.000000	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	1,151	340,373	341,524	0.815114	0.000000	90.00
91.00	09100	EMERGENCY	368,010	6,368,706	6,736,716	0.639920	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	266,992	243,168	510,160	0.625414	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0.000000	0.000000	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0.000000	0.000000	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0.000000	0.000000	111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,553,661	42,073,888	48,627,549			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,553,661	42,073,888	48,627,549			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet C Part I Date/Time Prepared: 5/29/2024 8:55 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
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
		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
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		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 (RHC)	0.000000		88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
		SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION	0.000000		109.00
110.00	11000	INTESTINAL ACQUISITION	0.000000		110.00
111.00	11100	ISLET ACQUISITION	0.000000		111.00
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: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part II Date/Time Prepared: 5/29/2024 8:55 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	100,809	1,113,053	0.090570	8,476	768	50.00
53.00	05300	ANESTHESIOLOGY	4,611	637,966	0.007228	14,605	106	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	128,560	12,303,366	0.010449	400,600	4,186	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	10,966	8,179,809	0.001341	345,364	463	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,610	756,411	0.002128	1,113	2	65.00
66.00	06600	PHYSICAL THERAPY	11,781	1,337,027	0.008811	37,638	332	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,050	340,670	0.023630	3,754	89	67.00
68.00	06800	SPEECH PATHOLOGY	5,949	4,738	1.255593	2,595	3,258	68.00
69.00	06900	ELECTROCARDIOLOGY	3,019	1,185,703	0.002546	39,445	100	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,435	402,262	0.008539	33,788	289	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,311	524,279	0.002501	117,924	295	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,794	4,281,467	0.001353	448,963	607	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	257,616	6,187,188	0.041637	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	40,443	1,619,391	0.024974	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	1,209	239,986	0.005038	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	1,286	341,524	0.003765	0	0	90.00
91.00	09100	EMERGENCY	31,020	6,736,716	0.004605	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	9,830	510,160	0.019268	95,964	1,849	92.00
200.00		Total (lines 50 through 199)	627,299	46,701,716		1,550,229	12,344	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 8:55 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 8:55 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,113,053	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	637,966	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,303,366	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	8,179,809	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	756,411	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,337,027	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	340,670	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,738	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,185,703	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	402,262	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	524,279	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,281,467	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	6,187,188	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,619,391	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	0	0	0	239,986	0.000000	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	341,524	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	6,736,716	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	510,160	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	46,701,716		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV Date/Time Prepared: 5/29/2024 8:55 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	8,476	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	14,605	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	400,600	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	345,364	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,113	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	37,638	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	3,754	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,595	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	39,445	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	33,788	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	117,924	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	448,963	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	0.000000	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	95,964	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,550,229	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 8:55 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	2.145352	0	262,821	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.016623	0	123,150	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158222	0	2,915,137	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.291150	0	1,990,677	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.303984	0	261,234	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.758436	0	410,541	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.004171	0	51,591	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8.470663	0	340	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.388178	0	477,548	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.550805	0	73,301	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.894108	0	59,234	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.490490	0	749,640	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)						88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.815114	0	34,452	0	0	90.00
91.00	09100	EMERGENCY	0.639920	0	1,360,809	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.625414	0	85,676	0	0	92.00
200.00		Subtotal (see instructions)		0	8,856,151	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	8,856,151	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V | Date/Time Prepared: 5/29/2024 8:55 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	563,844	0		50.00
53.00	05300	ANESTHESIOLOGY	125,197	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	461,239	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	579,586	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	79,411	0		65.00
66.00	06600	PHYSICAL THERAPY	311,369	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	51,806	0		67.00
68.00	06800	SPEECH PATHOLOGY	2,880	0		68.00
69.00	06900	ELECTROCARDIOLOGY	185,374	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	113,676	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,962	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	367,691	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)				88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	28,082	0		90.00
91.00	09100	EMERGENCY	870,809	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	53,583	0		92.00
200.00		Subtotal (see instructions)	3,847,509	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,847,509	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1309 | Component CCN: 14-Z309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 8:55 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1309 | Component CCN: 14-Z309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 8:55 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,113,053	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	637,966	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,303,366	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	8,179,809	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	756,411	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,337,027	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	340,670	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,738	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,185,703	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	402,262	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	524,279	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,281,467	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	6,187,188	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,619,391	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	0	0	0	239,986	0.000000	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	341,524	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	6,736,716	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	510,160	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	46,701,716		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1309 | Component CCN: 14-Z309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part IV | Date/Time Prepared: 5/29/2024 8:55 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	66,976	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	109,422	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	155,943	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	27,704	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,227	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,446	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	277	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	312,945	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	0.000000	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	649	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		679,589	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 8:55 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	2.145352	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.016623	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158222	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.291150	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.303984	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.758436	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.004171	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8.470663	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.388178	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.550805	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.894108	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.490490	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)						88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.815114	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.639920	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.625414	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D Part V Date/Time Prepared: 5/29/2024 8:55 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	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)			88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1309	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/29/2024 8:55 pm
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,726	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	851	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)	743	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	753	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	122	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)	337	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)	560	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	159.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	159.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,758,051	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)	19,398	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	2,243,963	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,514,088	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,514,088	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)	2,954.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	995,589	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)	995,589	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 8:55 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	0	0	0.00	0	0	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)	704,981	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)	1,700,570	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	1,654,391	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	1,654,391	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)	108	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,954.27	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	319,061	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-1 | Date/Time Prepared: 5/29/2024 8:55 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	146,589	4,758,051	0.030809	319,061	9,830	90.00
91.00	Nursing Program cost	0	4,758,051	0.000000	319,061	0	91.00
92.00	Allied health cost	0	4,758,051	0.000000	319,061	0	92.00
93.00	All other Medical Education	0	4,758,051	0.000000	319,061	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 8:55 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		727,482		30.00
33.00	03300	BURN INTENSIVE CARE UNIT		0		33.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2.145352	8,476	18,184	50.00
53.00	05300	ANESTHESIOLOGY	1.016623	14,605	14,848	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158222	400,600	63,384	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.291150	345,364	100,553	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.303984	1,113	338	65.00
66.00	06600	PHYSICAL THERAPY	0.758436	37,638	28,546	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.004171	3,754	3,770	67.00
68.00	06800	SPEECH PATHOLOGY	8.470663	2,595	21,981	68.00
69.00	06900	ELECTROCARDIOLOGY	0.388178	39,445	15,312	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.550805	33,788	52,399	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.894108	117,924	105,437	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.490490	448,963	220,212	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	0.000000		0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.815114	0	0	90.00
91.00	09100	EMERGENCY	0.639920	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.625414	95,964	60,017	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,550,229	704,981	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)		1,550,229		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1309 | Component CCN: 14-Z309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet D-3 | Date/Time Prepared: 5/29/2024 8:55 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
33.00	03300	BURN INTENSIVE CARE UNIT				33.00
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2.145352	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.016623	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158222	66,976	10,597	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.291150	109,422	31,858	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.303984	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.758436	155,943	118,273	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.004171	27,704	27,820	67.00
68.00	06800	SPEECH PATHOLOGY	8.470663	1,227	10,394	68.00
69.00	06900	ELECTROCARDIOLOGY	0.388178	4,446	1,726	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.550805	277	430	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.894108	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.490490	312,945	153,496	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC (RHC)	0.000000		0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.815114	649	529	90.00
91.00	09100	EMERGENCY	0.639920	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.625414	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		679,589	355,123	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)		679,589		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1309	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 8:55 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,847,509	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)	3,847,509	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	3,885,984	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)	28,862	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,405,347	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,451,775	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	2,451,775	30.00
31.00	Primary payer payments	652	31.00
32.00	Subtotal (line 30 minus line 31)	2,451,123	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)	61,615	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	40,050	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	61,615	36.00
37.00	Subtotal (see instructions)	2,491,173	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,491,173	40.00
40.01	Sequestration adjustment (see instructions)	49,823	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	2,750,312	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)	-308,962	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1309	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 8:55 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: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2024 8:55 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,298,744		2,580,085	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	09/05/2023	221,109	09/05/2023	134,199	3.01
3.02		12/04/2023	54,218	12/04/2023	36,028	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)		275,327		170,227	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,574,071		2,750,312	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		22,083		308,962	6.02
7.00	Total Medicare program liability (see instructions)		1,551,988		2,441,350	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1309 | Component CCN: 14-Z309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2024 8:55 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		1,964,442		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	09/05/2023	204,801		0	3.01
3.02		12/04/2023	13,870		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)		218,671		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,183,113		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		203,064		0	6.02
7.00	Total Medicare program liability (see instructions)		1,980,049		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1309	Period: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Prepared: 5/29/2024 8:55 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: 14-1309 | Component CCN: 14-Z309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet E-2 | Date/Time Prepared: 5/29/2024 8:55 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)	1,670,935	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)	358,674	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	560	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)	2,029,609	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,029,609	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)	2,029,609	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	9,151	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	2,020,458	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)	2,020,458	0	19.00
19.01	Sequestration adjustment (see instructions)	40,409	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	2,183,113	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)	-203,064	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: 14-1309	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/29/2024 8:55 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,700,570	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)	1,700,570	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,700,570	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)	1,700,570	19.00
20.00	Deductibles (exclude professional component)	120,000	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,580,570	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,580,570	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	4,756	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	3,091	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	4,756	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,583,661	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,583,661	30.00
30.01	Sequestration adjustment (see instructions)	31,673	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,574,071	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-22,083	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G | Date/Time Prepared: 5/29/2024 8:55 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	876,968	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	8,523,538	0	0	0	4.00
5.00	Other receivable	64,986	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,825,298	0	0	0	6.00
7.00	Inventory	115,302	0	0	0	7.00
8.00	Prepaid expenses	63,009	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)	4,818,505	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	3,276,114	0	0	0	23.00
24.00	Accumulated depreciation	-1,540,605	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)	1,735,509	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)	6,554,014	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	49,396	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,401,854	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	107,126	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	2,348,073	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,906,449	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)	3,906,449	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	2,647,565				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)	2,647,565	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	6,554,014	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-1 | Date/Time Prepared: 5/29/2024 8:55 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		874,278		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,773,287				2.00
3.00	Total (sum of line 1 and line 2)		2,647,565		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)		2,647,565		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)		2,647,565		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: 14-1309 | Period: From 01/01/2023 To 12/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2024 8:55 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,461,365		1,461,365	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	464,468		464,468	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)	1,925,833		1,925,833	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	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,925,833		1,925,833	17.00
18.00	Ancillary services	4,607,656	34,047,295	38,654,951	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	6,187,188	6,187,188	20.00
20.01	RURAL HEALTH CLINIC II	0	1,619,391	1,619,391	20.01
20.02	RURAL HEALTH CLINIC (RHC)	0	239,986	239,986	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	41,606	2,120,911	2,162,517	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,575,095	44,214,771	50,789,866	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,729,825		29.00
30.00	BAD DEBT	1,340,855			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)		1,340,855		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)		28,070,680		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1309	Period: From 01/01/2023 To 12/31/2023	Worksheet G-3 Date/Time Prepared: 5/29/2024 8:55 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	50,789,866	1.00
2.00	Less contractual allowances and discounts on patients' accounts	21,334,439	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,455,427	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,070,680	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,384,747	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER	388,540	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	388,540	25.00
26.00	Total (line 5 plus line 25)	1,773,287	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)	1,773,287	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1309 | Component CCN: 14-8581 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 8:55 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	1,437,081	283,419	1,720,500	0	1,720,500	1.00
2.00	Physician Assistant	78,248	15,432	93,680	0	93,680	2.00
3.00	Nurse Practitioner	75,169	14,825	89,994	0	89,994	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	447,374	88,230	535,604	0	535,604	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)	2,037,872	401,906	2,439,778	0	2,439,778	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	68,431	68,431	0	68,431	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	68,431	68,431	0	68,431	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,037,872	470,337	2,508,209	0	2,508,209	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	161,698	161,698	-149,918	11,780	29.00
30.00	Administrative Costs	610,124	376,520	986,644	0	986,644	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	610,124	538,218	1,148,342	-149,918	998,424	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,647,996	1,008,555	3,656,551	-149,918	3,506,633	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1309 | Component CCN: 14-8581 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 8:55 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	1,720,500		1.00
2.00	Physician Assistant	0	93,680		2.00
3.00	Nurse Practitioner	0	89,994		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	535,604		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	2,439,778		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	68,431		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	68,431		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,508,209		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	11,780		29.00
30.00	Administrative Costs	0	986,644		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	998,424		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	3,506,633		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1309 | Component CCN: 14-8582 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 8:55 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	396,197	89,005	485,202	0	485,202	1.00
2.00	Physician Assistant	150,506	33,811	184,317	0	184,317	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	83,751	18,814	102,565	0	102,565	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)	630,454	141,630	772,084	0	772,084	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	22,769	22,769	0	22,769	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	22,769	22,769	0	22,769	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	630,454	164,399	794,853	0	794,853	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	139,903	139,903	-64,393	75,510	29.00
30.00	Administrative Costs	142,533	78,551	221,084	0	221,084	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	142,533	218,454	360,987	-64,393	296,594	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	772,987	382,853	1,155,840	-64,393	1,091,447	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1309 | Component CCN: 14-8582 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 8:55 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	485,202		1.00
2.00	Physician Assistant	0	184,317		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	102,565		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	772,084		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	22,769		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	22,769		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	794,853		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	75,510		29.00
30.00	Administrative Costs	-12	221,072		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-12	296,582		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-12	1,091,435		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1309 | Component CCN: 14-8620 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 8:55 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	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	126,669	22,387	149,056	0	149,056	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	38,162	6,745	44,907	0	44,907	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)	164,831	29,132	193,963	0	193,963	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	6,022	6,022	0	6,022	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	6,022	6,022	0	6,022	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	164,831	35,154	199,985	0	199,985	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	23,584	23,584	6,192	29,776	29.00
30.00	Administrative Costs	70,326	27,876	98,202	0	98,202	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	70,326	51,460	121,786	6,192	127,978	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	235,157	86,614	321,771	6,192	327,963	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1309 | Component CCN: 14-8620 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-1 | Date/Time Prepared: 5/29/2024 8:55 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	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	149,056		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	44,907		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	193,963		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	6,022		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	6,022		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	199,985		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	29,776		29.00
30.00	Administrative Costs	-352	97,850		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-352	127,626		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-352	327,611		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1309 | Component CCN: 14-8581 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/29/2024 8:55 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	3.31	15,502	4,200	13,902		1.00
2.00	Physician Assistant	0.44	0	2,100	924		2.00
3.00	Nurse Practitioner	0.43	0	2,100	903		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.18	15,502		15,729	15,729	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)	4.18	15,502			15,729	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)	2,508,209	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)	2,508,209	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)	998,424	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,233,207	15.00
16.00	Total overhead (sum of lines 14 and 15)	2,231,631	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	2,231,631	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	2,231,631	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	4,739,840	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1309 | Component CCN: 14-8582 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/29/2024 8:55 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	0.45	5,445	4,200	1,890		1.00
2.00	Physician Assistant	0.84	0	2,100	1,764		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.29	5,445		3,654	5,445	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)	1.29	5,445			5,445	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)	794,853	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)	794,853	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)	296,582	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	406,501	15.00
16.00	Total overhead (sum of lines 14 and 15)	703,083	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	703,083	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	703,083	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,497,936	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1309 | Component CCN: 14-8620 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-2 | Date/Time Prepared: 5/29/2024 8:55 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	0.00	0	0	0		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	0.88	850	2,100	1,848		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.88	850		1,848	1,848	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
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)	0.88	850			1,848	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					199,985	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)					199,985	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)					127,626	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					124,229	15.00
16.00	Total overhead (sum of lines 14 and 15)					251,855	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					251,855	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					251,855	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					451,840	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1309 Component CCN: 14-8581	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 8:55 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			4,739,840	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			312,235	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			4,427,605	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			15,729	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)			15,729	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			281.49	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	295.11		8.00
9.00	Rate for Program covered visits (see instructions)	0.00	281.49		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	4,470		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,258,260		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	1,258,260		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,592,212		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0		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.)		917,390		16.04
16.05	Total program cost (see instructions)	0	917,390		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		111,522		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		263,494		19.00
20.00	Net program cost excluding injections/infusions (see instructions)		917,390		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		98,642		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)		1,016,032		22.00
23.00	Allowable bad debts (see instructions)		359		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		233		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		1,016,265		26.00
26.01	Sequestration adjustment (see instructions)		20,325		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		849,311		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)		146,629		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: 14-1309 Component CCN: 14-8582	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 8:55 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)		1,497,936	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		70,098	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,427,838	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		5,445	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)		5,445	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		262.23	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	318.50	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	262.23	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,811	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	474,899	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	474,899	16.00
16.01	Total program charges (see instructions)(from contractor's records)		460,233	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	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.)		355,204	16.04
16.05	Total program cost (see instructions)	0	355,204	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		30,894	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		79,602	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		355,204	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		20,110	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)		375,314	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		375,314	26.00
26.01	Sequestration adjustment (see instructions)		7,506	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		392,997	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)		-25,189	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: 14-1309 Component CCN: 14-8620	Period: From 01/01/2023 To 12/31/2023	Worksheet M-3 Date/Time Prepared: 5/29/2024 8:55 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)		451,840	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		8,303	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		443,537	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,848	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		1,848	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		240.01	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	222.18	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	222.18	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	149	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	33,105	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	33,105	16.00
16.01	Total program charges (see instructions)(from contractor's records)		39,570	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	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.)		23,360	16.04
16.05	Total program cost (see instructions)	0	23,360	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		3,905	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		6,098	19.00
20.00	Net program cost excluding injections/infusions (see instructions)		23,360	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,159	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)		26,519	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		26,519	26.00
26.01	Sequestration adjustment (see instructions)		530	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		62,166	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)		-36,177	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: 14-1309 | Component CCN: 14-8581 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/29/2024 8:55 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)	2,439,778	2,439,778	2,439,778	2,439,778	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.004900	0.014700	0.004200	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	11,955	35,865	10,247	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	68,963	38,198	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	80,918	74,063	10,247	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,508,209	2,508,209	2,508,209	2,508,209	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,231,631	2,231,631	2,231,631	2,231,631	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.032261	0.029528	0.004085	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	71,995	65,896	9,116	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	152,913	139,959	19,363	0	10.00
11.00	Total number of injections/infusions (from your records)	368	1,104	322	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	415.52	126.77	60.13	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	118	370	45	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)	49,031	46,905	2,706	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)		312,235	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)		98,642	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1309 | Component CCN: 14-8582 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/29/2024 8:55 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)	772,084	772,084	772,084	772,084	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.007170	0.015300	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	5,536	11,813	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	14,242	5,605	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	19,778	17,418	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	794,853	794,853	794,853	794,853	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	703,083	703,083	703,083	703,083	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.024883	0.021913	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	17,495	15,407	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	37,273	32,825	0	0	10.00
11.00	Total number of injections/infusions (from your records)	76	162	54	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	490.43	202.62	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	22	46	20	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)	10,789	9,321	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)		70,098	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)		20,110	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1309 | Component CCN: 14-8620 | Period: From 01/01/2023 To 12/31/2023 | Worksheet M-4 | Date/Time Prepared: 5/29/2024 8:55 pm

Title XVIII | RHC III | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	193,963	193,963	193,963	193,963	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.002100	0.004700	0.000700	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	407	912	136	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	346	1,874	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	753	2,786	136	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	199,985	199,985	199,985	199,985	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	251,855	251,855	251,855	251,855	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.003765	0.013931	0.000680	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	948	3,509	171	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1,701	6,295	307	0	10.00
11.00	Total number of injections/infusions (from your records)	12	27	4	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	141.75	233.15	76.75	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	2	12	1	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)	284	2,798	77	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)		8,303	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)		3,159	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1309 Component CCN: 14-8581	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 8:55 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		884,891	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		09/05/2023	35,580	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)		-35,580	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		849,311	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		146,629	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		995,940	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1309 Component CCN: 14-8582	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 8:55 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		406,950	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		09/05/2023	13,953	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)		-13,953	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		392,997	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		25,189	6.02
7.00	Total Medicare program liability (see instructions)		367,808	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1309 Component CCN: 14-8620	Period: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 8:55 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		36,671	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		09/05/2023	25,495	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)		25,495	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		62,166	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		36,177	6.02
7.00	Total Medicare program liability (see instructions)		25,989	7.00

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