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: 14-1337	Period: From 10/01/2022 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/22/2024 4:36 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/22/2024 Time: 4:36 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 OSF SAINT CLARE MEDICAL CENTER (14-1337) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1				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	VICE PRESIDENT STRATEGIC REIMBURSI			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	-413,440	-1,850,531	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	-48,971	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-22,475		0	10.00
10.01	RURAL HEALTH CLINIC - HENRY II	0		7,955		0	10.01
200.00	TOTAL	0	-462,411	-1,865,051	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/22/2024 4:36 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 530 PARK AVENUE EAST	PO Box:			1.00
2.00	City: PRINCETON	State: IL	Zip Code: 61356	County: BUREAU	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	OSF SAINT CLARE MEDICAL CENTER	141337	99914	1	07/15/2004	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	OSF SAINT CLARE MEDICAL CENTER	14Z337	99914		07/15/2004	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	OSF HEALTHCARE - COMMUNITY HEALTH	148549	99914		11/04/2015	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	OSF HEALTHCARE MEDICAL GROUP - HENRY	148647	99914		03/02/2023	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2022	09/30/2023	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.	2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/22/2024 4:36 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 St	Date of Geogra	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/22/2024 4:36 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: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 2/22/2024 4:36 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: 14-1337	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part I Date/Time Prepared: 2/22/2024 4:36 pm

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

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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 2/22/2024 4:36 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	182,239	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y		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	HB1728	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: OSF HEALTHCARE SYSTEM	Contractor's Name: WPS	Contractor's Number: 00131	141.00
142.00	Street: 800 NE GLEN OAK AVE	PO Box:		142.00
143.00	City: PEORIA	State: IL	Zip Code: 61603	143.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 2/22/2024 4:36 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/21/2023	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/13/2023	Y	12/13/2023	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-2 Part II Date/Time Prepared: 2/22/2024 4:36 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	SPLITTING OF REVENUE CODES		Y	Y	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				Y	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	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.	MICHELLE		CARROTHERS		41.00
42.00	Enter the employer/company name of the cost report preparer	OSF HEALTHCARE				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	906-786-5707		MICHELLE.A.CARROTHERS@OSFHEALTHCARE.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1337	Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part II Date/Time Prepared: 2/22/2024 4:36 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VP STRATEGIC REIMBURSEMENT		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: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I Date/Time Prepared: 2/22/2024 4:36 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	22	8,030	25,138.04	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		22	8,030	25,138.04	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	3	1,095	510.42	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	25,648.46	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC - HENRY	88.01				0	26.01
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: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/22/2024 4:36 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)	584	8	1,016			1.00
2.00	HMO and other (see instructions)	280	69				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	64	0	74			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	28			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	648	8	1,118			7.00
8.00	INTENSIVE CARE UNIT	19	0	43			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)	667	8	1,161	0.00	138.40	14.00
15.00	CAH visits	5,212	3,939	12,752			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	7,253	0	29,296	0.00	41.56	26.00
26.01	RURAL HEALTH CLINIC - HENRY	158	0	998	0.00	2.72	26.01
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	182.68	27.00
28.00	Observation Bed Days		0	716			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: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 2/22/2024 4:36 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	256	10	488	1.00
2.00	HMO and other (see instructions)			91	58		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	256	10	488	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC - HENRY	0.00					26.01
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: 14-1337 | Component CCN: 14-8549 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/22/2024 4:36 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			535 PARK AVENUE EAST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	PRINCETON		IL	61356	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	18:00	07:00	11.00

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

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

			County			
			4.00			
2.00	City, State, ZIP Code, County		BUREAU			2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	19:00	07:00	19:00	07:00	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1337
Component CCN: 14-8549

Period:
From 10/01/2022
To 09/30/2023

Worksheet S-8
Date/Time Prepared:
2/22/2024 4:36 pm

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	18:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1337 | Component CCN: 14-8647 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-8 | Date/Time Prepared: 2/22/2024 4:36 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			327 EDWARD STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	HENRY		IL	61537	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		11.00

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		MARSHALL				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		08:00	17:00	07:30	12:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1337
Component CCN: 14-8647

Period:
From 10/01/2022
To 09/30/2023

Worksheet S-8
Date/Time Prepared:
2/22/2024 4:36 pm

RHC II | Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet S-10 Parts I & II Date/Time Prepared: 2/22/2024 4:36 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)	0.322071	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,011,315	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	18,175,312	6.00
7.00	Medicaid cost (line 1 times line 6)	5,853,741	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)	2,842,426	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)	2,842,426	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)	926,696	279,497	1,206,193	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	298,462	279,497	577,959	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)	298,462	279,497	577,959	23.00

		1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
25.01	Charges for insured patients' liability (see instructions)	0	25.01
26.00	Bad debt amount (see instructions)	1,677,648	26.00
27.00	Medicare reimbursable bad debts (see instructions)	262,691	27.00
27.01	Medicare allowable bad debts (see instructions)	404,140	27.01
28.00	Non-Medicare bad debt amount (see instructions)	1,273,508	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	551,609	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1,129,568	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,971,994	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1337	Period: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/22/2024 4:36 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: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/22/2024 4:36 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		-455,111	-455,111	24,111	-431,000	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,063,046	1,063,046	27,255	1,090,301	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	329,009	685,775	1,014,784	-545,200	469,584	4.00
5.01	00590	BUSINESS OFFICE	0	1,818,298	1,818,298	0	1,818,298	5.01
5.02	00591	A&G HOSPITAL-ONLY	364,958	371,696	736,654	-25,238	711,416	5.02
5.03	00592	A&G SHARED	991,105	5,815,011	6,806,116	-10,018	6,796,098	5.03
7.00	00700	OPERATION OF PLANT	355,338	2,323,482	2,678,820	-516,850	2,161,970	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	38,202	121,904	160,106	911	161,017	8.00
9.00	00900	HOUSEKEEPING	412,046	268,723	680,769	8,962	689,731	9.00
10.00	01000	DIETARY	297,554	649,487	947,041	5,982	953,023	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	11,254	13,545	24,799	52,903	77,702	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	61,516	54,243	115,759	1,605	117,364	14.00
15.00	01500	PHARMACY	326,602	399,763	726,365	4,716	731,081	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,407	1,407	0	1,407	16.00
17.00	01700	SOCIAL SERVICE	0	361,417	361,417	0	361,417	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,512,499	529,746	2,042,245	41,776	2,084,021	30.00
31.00	03100	INTENSIVE CARE UNIT	2,723	8,232	10,955	51,292	62,247	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,193,316	819,751	2,013,067	61,207	2,074,274	50.00
53.00	05300	ANESTHESIOLOGY	5,500	934,915	940,415	79	940,494	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	648,615	333,645	982,260	454,722	1,436,982	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	235,312	94,304	329,616	4,366	333,982	55.00
56.00	05600	RADIOISOTOPE	0	191,707	191,707	0	191,707	56.00
57.00	05700	CT SCAN	172,086	105,985	278,071	2,844	280,915	57.00
58.00	05800	MRI	102,876	121,494	224,370	1,844	226,214	58.00
60.00	06000	LABORATORY	791,374	1,401,807	2,193,181	104,820	2,298,001	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	124,951	124,951	0	124,951	63.00
65.00	06500	RESPIRATORY THERAPY	396,512	114,623	511,135	22,262	533,397	65.00
66.00	06600	PHYSICAL THERAPY	646,118	197,297	843,415	15,229	858,644	66.00
68.00	06800	SPEECH PATHOLOGY	11,430	3,445	14,875	165	15,040	68.00
69.00	06900	ELECTROCARDIOLOGY	116,133	96,823	212,956	3,222	216,178	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,889	7,420	14,309	99	14,408	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	221,164	221,164	52,525	273,689	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	579,773	579,773	0	579,773	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,621,483	1,621,483	2,396	1,623,879	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	609,094	609,094	0	609,094	76.01
76.97	07697	CARDIAC REHABILITATION	156,706	24,052	180,758	6,430	187,188	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,740,919	2,194,383	5,935,302	57,852	5,993,154	88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	199,604	133,787	333,391	-77,613	255,778	88.01
90.00	09000	CLINIC	403,201	171,918	575,119	17,075	592,194	90.00
90.01	04950	SLEEP LAB	84,017	35,689	119,706	1,572	121,278	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	75,437	271,984	347,421	1,806	349,227	90.03
91.00	09100	EMERGENCY	1,597,608	3,250,238	4,847,846	64,172	4,912,018	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,286,459	27,692,396	42,978,855	-80,719	42,898,136	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,535	88,400	103,935	224	104,159	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,501	1,501	0	1,501	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	0	0	80,495	80,495	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	0	0	0	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
200.00		TOTAL (SUM OF LINES 118 through 199)	15,301,994	27,782,297	43,084,291	0	43,084,291	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A | Date/Time Prepared: 2/22/2024 4:36 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	1,217,565	786,565		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	492,872	1,583,173		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	469,584		4.00
5.01	00590	BUSINESS OFFICE	1,348,878	3,167,176		5.01
5.02	00591	A&G HOSPITAL-ONLY	-14,835	696,581		5.02
5.03	00592	A&G SHARED	-1,822,687	4,973,411		5.03
7.00	00700	OPERATION OF PLANT	-10,333	2,151,637		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-1,793	159,224		8.00
9.00	00900	HOUSEKEEPING	0	689,731		9.00
10.00	01000	DIETARY	-175,151	777,872		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	399,970	477,672		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	117,364		14.00
15.00	01500	PHARMACY	0	731,081		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,407		16.00
17.00	01700	SOCIAL SERVICE	-57,834	303,583		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-31,211	2,052,810		30.00
31.00	03100	INTENSIVE CARE UNIT	0	62,247		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,074,274		50.00
53.00	05300	ANESTHESIOLOGY	-903,126	37,368		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,436,982		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	333,982		55.00
56.00	05600	RADIOISOTOPE	0	191,707		56.00
57.00	05700	CT SCAN	0	280,915		57.00
58.00	05800	MRI	0	226,214		58.00
60.00	06000	LABORATORY	-9,153	2,288,848		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	124,951		63.00
65.00	06500	RESPIRATORY THERAPY	0	533,397		65.00
66.00	06600	PHYSICAL THERAPY	3,287	861,931		66.00
68.00	06800	SPEECH PATHOLOGY	0	15,040		68.00
69.00	06900	ELECTROCARDIOLOGY	0	216,178		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	14,408		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	273,689		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	579,773		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-161,685	1,462,194		73.00
76.00	03140	CARDIOLOGY	0	0		76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	-208,080	401,014		76.01
76.97	07697	CARDIAC REHABILITATION	-7,852	179,336		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-302,127	5,691,027		88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	0	255,778		88.01
90.00	09000	CLINIC	0	592,194		90.00
90.01	04950	SLEEP LAB	0	121,278		90.01
90.02	09001	GENERAL SURGERY CL	0	0		90.02
90.03	09002	PM PAIN CLINIC	-230,887	118,340		90.03
91.00	09100	EMERGENCY	-1,826,581	3,085,437		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,300,763	40,597,373		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	104,159		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,501		192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0		192.03
194.00	07956	WALNUT & HENRY CLINICS	0	80,495		194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0		194.01
194.02	07950	PERRY HOME CARE - HHA	0	0		194.02
194.03	07953	MOB LEASED SPACE	0	0		194.03
194.05	07955	PERRY PLAZA LEASED	0	0		194.05
194.06	07954	PM PROMPT CARE	0	0		194.06
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,300,763	40,783,528		200.00

RECLASSIFICATIONS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/22/2024 4:36 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	B - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	24,111	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	27,255	2.00
	TOTALS		0	51,366	
	E - RETENTION BONUSES				
1.00		0.00	0	0	1.00
3.00	ADULTS & PEDIATRICS	30.00	61,180	0	3.00
4.00	OPERATING ROOM	50.00	42,683	0	4.00
5.00	RESPIRATORY THERAPY	65.00	10,671	0	5.00
6.00	CARDIAC REHABILITATION	76.97	3,557	0	6.00
7.00	ELECTROCARDIOLOGY	69.00	1,186	0	7.00
8.00	CLINIC	90.00	11,857	0	8.00
9.00	EMERGENCY	91.00	45,055	0	9.00
	TOTALS		176,189	0	
	F - VACATION AND OTHER				
1.00		0.00	0	0	1.00
2.00	A&G HOSPITAL-ONLY	5.02	0	5,270	2.00
3.00	A&G SHARED	5.03	0	14,310	3.00
4.00	OPERATION OF PLANT	7.00	0	5,131	4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	0	552	5.00
6.00	HOUSEKEEPING	9.00	0	5,949	6.00
7.00	DIETARY	10.00	0	4,296	7.00
8.00	NURSING ADMINISTRATION	13.00	0	162	8.00
9.00	CENTRAL SERVICES & SUPPLY	14.00	0	888	9.00
10.00	PHARMACY	15.00	0	4,716	10.00
12.00	ADULTS & PEDIATRICS	30.00	0	21,839	12.00
13.00	INTENSIVE CARE UNIT	31.00	0	39	13.00
14.00	OPERATING ROOM	50.00	0	17,230	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,365	15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	3,398	16.00
17.00	CT SCAN	57.00	0	2,485	17.00
18.00	MRI	58.00	0	1,485	18.00
19.00	LABORATORY	60.00	0	11,427	19.00
20.00	RESPIRATORY THERAPY	65.00	0	5,725	20.00
21.00	PHYSICAL THERAPY	66.00	0	9,329	21.00
22.00	SPEECH PATHOLOGY	68.00	0	165	22.00
23.00	ELECTROCARDIOLOGY	69.00	0	1,677	23.00
24.00	CARDIAC REHABILITATION	76.97	0	2,263	24.00
25.00	RURAL HEALTH CLINIC	88.00	0	54,015	25.00
26.00	CLINIC	90.00	0	3,425	26.00
27.00	SLEEP LAB	90.01	0	1,213	27.00
28.00	PM PAIN CLINIC	90.03	0	1,089	28.00
29.00	EMERGENCY	91.00	0	23,068	29.00
30.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	224	30.00
31.00	ANESTHESIOLOGY	53.00	0	79	31.00
32.00	ELECTROENCEPHALOGRAPHY	70.00	0	99	32.00
33.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,396	33.00
34.00	RURAL HEALTH CLINIC - HENRY	88.01	0	2,882	34.00
	TOTALS		0	216,191	
	G - RECLASS MED SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	21,658	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	21,658	
	H - RECLASS PCI TECH COSTS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	437,672	1.00
2.00	LABORATORY	60.00	0	84,309	2.00
	TOTALS		0	521,981	
	I - RECLASS PREMIER CONTRACT ADMIN FEES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	30,867	1.00
	TOTALS		0	30,867	
	J - RECLASS NON-RHC SALARIES AND BENEFIT				
1.00	WALNUT & HENRY CLINICS	194.00	44,829	12,513	1.00
	TOTALS		44,829	12,513	
	K - RECLASS ICU SALARIES AND BENEFITS				
1.00	INTENSIVE CARE UNIT	31.00	41,116	10,137	1.00
	TOTALS		41,116	10,137	
	L - RECLASS NON-RHC OTHER COSTS				
1.00	WALNUT & HENRY CLINICS	194.00	0	23,153	1.00
	TOTALS		0	23,153	

RECLASSIFICATIONS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/22/2024 4:36 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	M - NURSING ADMIN COSTS				
1.00	NURSING ADMINISTRATION	13.00	46,420	6,070	1.00
	TOTALS		46,420	6,070	
	N - TEAM AWARDS AND INCENTIVE COMP				
1.00	A&G HOSPITAL-ONLY	5.02	359	0	1.00
2.00	A&G SHARED	5.03	79,528	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	359	0	3.00
4.00	HOUSEKEEPING	9.00	3,013	0	4.00
5.00	DIETARY	10.00	1,686	0	5.00
6.00	NURSING ADMINISTRATION	13.00	251	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	717	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	10,010	0	8.00
9.00	OPERATING ROOM	50.00	9,112	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	7,685	0	10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	968	0	11.00
12.00	CT SCAN	57.00	359	0	12.00
13.00	MRI	58.00	359	0	13.00
14.00	LABORATORY	60.00	9,084	0	14.00
15.00	RESPIRATORY THERAPY	65.00	5,866	0	15.00
16.00	PHYSICAL THERAPY	66.00	5,900	0	16.00
17.00	ELECTROCARDIOLOGY	69.00	359	0	17.00
18.00	CARDIAC REHABILITATION	76.97	610	0	18.00
19.00	RURAL HEALTH CLINIC	88.00	3,837	0	19.00
20.00	CLINIC	90.00	1,793	0	20.00
21.00	SLEEP LAB	90.01	359	0	21.00
22.00	PM PAIN CLINIC	90.03	717	0	22.00
23.00	EMERGENCY	91.00	9,889	0	23.00
	TOTALS		152,820	0	
500.00	Grand Total: Increases		461,374	893,936	500.00

RECLASSIFICATIONS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/22/2024 4:36 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	B - PROPERTY INSURANCE					
1.00	A&G SHARED	5.03	0	51,366	12	1.00
2.00		0.00	0	0	12	2.00
	TOTALS		0	51,366		
	E - RETENTION BONUSES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	176,189	0	0	1.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
	TOTALS		176,189	0		
	F - VACATION AND OTHER					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	216,191	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
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
21.00		0.00	0	0	0	21.00
22.00		0.00	0	0	0	22.00
23.00		0.00	0	0	0	23.00
24.00		0.00	0	0	0	24.00
25.00		0.00	0	0	0	25.00
26.00		0.00	0	0	0	26.00
27.00		0.00	0	0	0	27.00
28.00		0.00	0	0	0	28.00
29.00		0.00	0	0	0	29.00
30.00		0.00	0	0	0	30.00
31.00		0.00	0	0	0	31.00
32.00		0.00	0	0	0	32.00
33.00		0.00	0	0	0	33.00
34.00		0.00	0	0	0	34.00
	TOTALS		0	216,191		
	G - RECLASS MED SUPPLIES					
1.00	EMERGENCY	91.00	0	13,840	0	1.00
2.00	OPERATING ROOM	50.00	0	7,818	0	2.00
	TOTALS		0	21,658		
	H - RECLASS PCI TECH COSTS					
1.00	OPERATION OF PLANT	7.00	0	521,981	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	521,981		
	I - RECLASS PREMIER CONTRACT ADMIN FEES					
1.00	A&G HOSPITAL-ONLY	5.02	0	30,867	0	1.00
	TOTALS		0	30,867		
	J - RECLASS NON-RHC SALARIES AND BENEFIT					
1.00	RURAL HEALTH CLINIC - HENRY	88.01	44,829	12,513	0	1.00
	TOTALS		44,829	12,513		
	K - RECLASS ICU SALARIES AND BENEFITS					
1.00	ADULTS & PEDIATRICS	30.00	41,116	10,137	0	1.00
	TOTALS		41,116	10,137		
	L - RECLASS NON-RHC OTHER COSTS					
1.00	RURAL HEALTH CLINIC - HENRY	88.01	0	23,153	0	1.00
	TOTALS		0	23,153		
	M - NURSING ADMIN COSTS					
1.00	A&G SHARED	5.03	46,420	6,070	0	1.00
	TOTALS		46,420	6,070		

RECLASSIFICATIONS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-6 | Date/Time Prepared: 2/22/2024 4:36 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	N - TEAM AWARDS AND INCENTIVE COMP					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	152,820	0	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
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
21.00		0.00	0	0	0	21.00
22.00		0.00	0	0	0	22.00
23.00		0.00	0	0	0	23.00
	TOTALS		152,820	0		
500.00	Grand Total: Decreases		461,374	893,936		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 2/22/2024 4:36 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	320,233	0	0	0	0	1.00
2.00	Land Improvements	92,482	0	0	0	0	2.00
3.00	Buildings and Fixtures	8,818,716	298,159	0	298,159	307	3.00
4.00	Building Improvements	1,644,007	800,305	0	800,305	6,052	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	10,875,438	1,098,464	0	1,098,464	6,359	8.00
9.00	Reconciling Items	-298,006	-368,416	0	-368,416	0	9.00
10.00	Total (line 8 minus line 9)	11,173,444	1,466,880	0	1,466,880	6,359	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	320,233	0	1.00
2.00	Land Improvements	92,482	0	2.00
3.00	Buildings and Fixtures	9,116,568	0	3.00
4.00	Building Improvements	2,438,260	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	11,967,543	0	8.00
9.00	Reconciling Items	-666,422	0	9.00
10.00	Total (line 8 minus line 9)	12,633,965	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 2/22/2024 4:36 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	-455,111	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,063,046	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	607,935	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	-455,111		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,063,046		2.00
3.00	Total (sum of lines 1-2)	0	607,935		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-7 Part III Date/Time Prepared: 2/22/2024 4:36 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	9,116,569	0	9,116,569	0.788983	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,438,260	0	2,438,260	0.211017	0	2.00
3.00	Total (sum of lines 1-2)	11,554,829	0	11,554,829	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	762,454	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,555,918	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,318,372	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	24,111	0	0	786,565	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	27,255	0	0	1,583,173	2.00
3.00	Total (sum of lines 1-2)	0	51,366	0	0	2,369,738	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/22/2024 4:36 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-2,923,786			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	930,372			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-611	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	CAFETERIA	B	-130,978	DIETARY	10.00	0	33.00
33.01	DIETICIAN REVENUE	B	-23,331	DIETARY	10.00	0	33.01
33.02	MALPRACTICE INSURANCE	A	4,115	A&G SHARED	5.03	0	33.02

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8 | Date/Time Prepared: 2/22/2024 4:36 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.03	MEDICAL RECORDS		0		0.00	0	33.03
33.04	CONTRACT NURSING	B	-16,822	NURSING ADMINISTRATION	13.00	0	33.04
33.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.05
33.06	MOBILE MEALS	B	-20,842	DIETARY	10.00	0	33.06
33.07	CARDIAC REHAB	B	-7,852	CARDIAC REHABILITATION	76.97	0	33.07
33.08	TELEPHONE EXPENSE	A	-10,333	OPERATION OF PLANT	7.00	0	33.08
33.09	340B EXPNESES	A	-154,626	DRUGS CHARGED TO PATIENTS	73.00	0	33.09
33.11	RHC MISC REVENUE	B	-17,448	RURAL HEALTH CLINIC	88.00	0	33.11
33.12	DUPLICATE EXPENSE OFFSET	A	-208,080	SENIOR BEHAVIORAL WELLNESS	76.01	0	33.12
33.13	IMPAIRMENT OF ASSETS	A	-19,033	CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
33.14	IMPAIRMENT OF ASSETS	A	1,414,597	CAP REL COSTS-BLDG & FIXT	1.00	9	33.14
33.15	NON-ALLOWABLE MARKETING	A	-12,762	A&G SHARED	5.03	0	33.15
33.16	OTHER REVENUE		0		0.00	0	33.16
33.17	OTHER REVENUE	B	-14,835	A&G HOSPITAL-ONLY	5.02	0	33.17
33.18	IDPA PROVIDER TAX	A	-1,123,494	A&G SHARED	5.03	0	33.18
33.21	IHA DUES OFFSET	A	-17,610	A&G SHARED	5.03	0	33.21
33.22	MEDICARE RELIFING ADJUSTMENT	A	61,608	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.22
33.23	NON-ALLOWABLE RHC EXPENSES	A	0	RURAL HEALTH CLINIC	88.00	0	33.23
33.24	OTHER REVENUE	B	-1,793	LAUNDRY & LINEN SERVICE	8.00	0	33.24
33.25	OTHER REVENUE	B	-160	A&G SHARED	5.03	0	33.25
33.26	OTHER REVENUE	B	-7,059	DRUGS CHARGED TO PATIENTS	73.00	0	33.26
33.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.27
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,300,763				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: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-1 | Date/Time Prepared: 2/22/2024 4:36 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	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL BLDG HO BLDG CAPITAL	174,154	352,153	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	431,875	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	MINISTRY ALLOCATION	192,634	192,634	3.00
3.01	5.01	BUSINESS OFFICE	HO FUNCTIONAL - REV CYCLE	3,062,639	1,713,761	3.01
3.02	5.03	A&G SHARED	MINISTRY ALLOCATION - A&G	2,910,612	3,582,724	3.02
3.03	5.03	A&G SHARED	HO FUNCTIONAL - A&G	186,059	186,059	3.03
3.04	7.00	OPERATION OF PLANT	MINISTRY ALLOCATION - PLANT	103,523	103,523	3.04
3.05	15.00	PHARMACY	MINISTRY ALLOCATION - PHARMA	45,799	45,799	3.05
3.06	13.00	NURSING ADMINISTRATION	HO FUNCTIONAL - NURSING ADMI	416,792	0	3.06
3.07	15.00	PHARMACY	HO FUNCTIONAL - E-PHARMACY	87,329	87,329	3.07
3.08	17.00	SOCIAL SERVICE	HO FUNCTIONAL - CARE MANAGEM	300,916	358,750	3.08
3.09	66.00	PHYSICAL THERAPY	HO FUNCTIONAL - REHAB ADMIN	32,158	28,871	3.09
3.10	30.00	ADULTS & PEDIATRICS	OSFMG MINISTRY ALLOCATION	0	31,211	3.10
4.00	30.00	ADULTS & PEDIATRICS	OSFMG MANAGEMENT SERVICES	11,455	11,455	4.00
4.01	53.00	ANESTHESIOLOGY	OSFMG MINISTRY ALLOCATION	0	14,506	4.01
4.02	53.00	ANESTHESIOLOGY	OSFMG MANAGEMENT SERVICES	986	986	4.02
4.03	88.00	RURAL HEALTH CLINIC	OSFMG MINISTRY ALLOCATION	0	284,679	4.03
4.04	88.00	RURAL HEALTH CLINIC	OSFMG MANAGEMENT SERVICES	309,826	309,826	4.04
4.05	88.01	RURAL HEALTH CLINIC - HENRY	OSFMG MANAGEMENT SERVICES	28,820	28,820	4.05
4.06	91.00	EMERGENCY	OSFMG MINISTRY ALLOCATION	0	31,455	4.06
4.07	91.00	EMERGENCY	OSFMG MANAGEMENT SERVICES	2,139	2,139	4.07
4.08	5.03	A&G SHARED	ST. GABRIEL	275,146	275,810	4.08
4.09	7.00	OPERATION OF PLANT	PCI PURCH SVCS - HTS - PLANT	305,361	305,361	4.09
4.10	54.00	RADIOLOGY-DIAGNOSTIC	PCI PURCH SVCS - HTS - RADIO	437,672	437,672	4.10
4.11	60.00	LABORATORY	PCI PURCH SVCS - HTS - LABOR	84,309	84,309	4.11
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,400,204	8,469,832	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:					
6.00	B		0.00	OSF HEALTHCARE	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

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.

(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: 14-1337	Period: From 10/01/2022 To 09/30/2023	Worksheet A-8-1 Date/Time Prepared: 2/22/2024 4:36 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	-177,999	9		1.00
2.00	431,875	9		2.00
3.00	0	0		3.00
3.01	1,348,878	0		3.01
3.02	-672,112	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	416,792	0		3.06
3.07	0	0		3.07
3.08	-57,834	0		3.08
3.09	3,287	0		3.09
3.10	-31,211	0		3.10
4.00	0	0		4.00
4.01	-14,506	0		4.01
4.02	0	0		4.02
4.03	-284,679	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	-31,455	0		4.06
4.07	0	0		4.07
4.08	-664	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
5.00	930,372			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 2/22/2024 4:36 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	53.00	ANESTHESIOLOGY	888,620	888,620	0	0	0	1.00
2.00	60.00	LABORATORY	9,153	9,153	0	0	0	2.00
3.00	91.00	EMERGENCY	2,499,502	1,795,126	704,376	0	0	3.00
4.00	90.03	PM PAIN CLINIC	230,887	230,887	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			3,628,162	2,923,786	704,376		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	53.00	ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	90.03	PM PAIN CLINIC	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	53.00	ANESTHESIOLOGY	0	0	0	888,620		1.00
2.00	60.00	LABORATORY	0	0	0	9,153		2.00
3.00	91.00	EMERGENCY	0	0	0	1,795,126		3.00
4.00	90.03	PM PAIN CLINIC	0	0	0	230,887		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	2,923,786		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/22/2024 4:36 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	BUSINESS OFFICE	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	786,565	786,565				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,583,173		1,583,173			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	469,584	2,793	0	472,377		4.00
5.01	00590	BUSINESS OFFICE	3,167,176	3,608	127	0	3,170,911	5.01
5.02	00591	A&G HOSPITAL-ONLY	696,581	29,020	106,256	11,277	0	5.02
5.03	00592	A&G SHARED	4,973,411	66,213	361,400	31,617	0	5.03
7.00	00700	OPERATION OF PLANT	2,151,637	227,311	201,430	10,969	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	159,224	2,992	0	1,190	0	8.00
9.00	00900	HOUSEKEEPING	689,731	6,210	3,856	12,813	0	9.00
10.00	01000	DIETARY	777,872	18,712	13,679	9,238	0	10.00
11.00	01100	CAFETERIA	0	9,302	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	477,672	8,426	0	1,788	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	117,364	6,674	8,797	1,921	0	14.00
15.00	01500	PHARMACY	731,081	7,094	19,417	10,082	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,407	15,173	1,452	0	0	16.00
17.00	01700	SOCIAL SERVICE	303,583	2,264	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,052,810	72,345	26,903	47,619	69,377	30.00
31.00	03100	INTENSIVE CARE UNIT	62,247	12,936	11,859	1,353	3,657	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,074,274	72,085	211,764	38,437	343,005	50.00
53.00	05300	ANESTHESIOLOGY	37,368	650	70,375	170	38,276	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,436,982	13,434	253,877	20,260	160,372	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	333,982	1,240	25	7,294	71,174	55.00
56.00	05600	RADIOISOTOPE	191,707	3,200	0	0	23,584	56.00
57.00	05700	CT SCAN	280,915	3,634	1,344	5,323	449,606	57.00
58.00	05800	MRI	226,214	4,176	3,908	3,187	106,382	58.00
60.00	06000	LABORATORY	2,288,848	14,566	41,924	24,710	602,012	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	124,951	0	0	0	13,321	63.00
65.00	06500	RESPIRATORY THERAPY	533,397	6,175	16,965	12,751	25,863	65.00
66.00	06600	PHYSICAL THERAPY	861,931	19,054	9,007	20,128	121,995	66.00
68.00	06800	SPEECH PATHOLOGY	15,040	286	0	353	3,253	68.00
69.00	06900	ELECTROCARDIOLOGY	216,178	1,578	14,610	3,633	72,587	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,408	317	3,162	213	358	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	273,689	0	0	0	17,173	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	579,773	0	0	0	39,076	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,462,194	0	0	0	314,249	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	401,014	5,611	0	0	9,330	76.01
76.97	07697	CARDIAC REHABILITATION	179,336	3,803	7,709	4,966	15,102	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,691,027	0	129,957	115,605	226,725	88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	255,778	0	6,261	4,778	8,385	88.01
90.00	09000	CLINIC	592,194	41,474	6,538	12,868	41,287	90.00
90.01	04950	SLEEP LAB	121,278	3,539	1,393	2,605	16,328	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	118,340	4,978	10,404	2,351	24,624	90.03
91.00	09100	EMERGENCY	3,085,437	33,772	38,774	51,014	353,810	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,597,373	724,645	1,583,173	470,513	3,170,911	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	104,159	2,402	0	480	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,501	1,778	0	0	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	80,495	0	0	1,384	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	5,000	0	0	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	52,740	0	0	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	40,783,528	786,565	1,583,173	472,377	3,170,911	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/22/2024 4:36 pm

		Cost Center Description	Subtotal	A&G HOSPITAL-ONLY	Subtotal	A&G SHARED	OPERATION OF PLANT	
			5A.01	5.02	5A.02	5.03	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	BUSINESS OFFICE						5.01
5.02	00591	A&G HOSPITAL-ONLY	843,134	843,134				5.02
5.03	00592	A&G SHARED	5,432,641	114,683	5,547,324	5,547,324		5.03
7.00	00700	OPERATION OF PLANT	2,591,347	54,703	2,646,050	416,576	3,062,626	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	163,406	3,450	166,856	26,269	20,025	8.00
9.00	00900	HOUSEKEEPING	712,610	15,043	727,653	114,557	41,559	9.00
10.00	01000	DIETARY	819,501	17,300	836,801	131,740	125,228	10.00
11.00	01100	CAFETERIA	9,302	196	9,498	1,495	62,251	11.00
13.00	01300	NURSING ADMINISTRATION	487,886	10,299	498,185	78,431	56,389	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	134,756	2,845	137,601	21,663	44,664	14.00
15.00	01500	PHARMACY	767,674	16,206	783,880	123,409	47,479	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,032	381	18,413	2,899	101,547	16.00
17.00	01700	SOCIAL SERVICE	305,847	6,456	312,303	49,167	15,149	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,269,054	47,900	2,316,954	364,765	484,169	30.00
31.00	03100	INTENSIVE CARE UNIT	92,052	1,943	93,995	14,798	86,572	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,739,565	57,832	2,797,397	440,403	482,427	50.00
53.00	05300	ANESTHESIOLOGY	146,839	3,100	149,939	23,605	4,353	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,884,925	39,791	1,924,716	303,014	89,909	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	413,715	8,734	422,449	66,507	8,300	55.00
56.00	05600	RADIOISOTOPE	218,491	4,612	223,103	35,124	21,418	56.00
57.00	05700	CT SCAN	740,822	15,639	756,461	119,092	24,320	57.00
58.00	05800	MRI	343,867	7,259	351,126	55,279	27,948	58.00
60.00	06000	LABORATORY	2,972,060	62,740	3,034,800	477,778	97,484	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	138,272	2,919	141,191	22,228	0	63.00
65.00	06500	RESPIRATORY THERAPY	595,151	12,564	607,715	95,674	41,327	65.00
66.00	06600	PHYSICAL THERAPY	1,032,115	21,788	1,053,903	165,919	127,521	66.00
68.00	06800	SPEECH PATHOLOGY	18,932	400	19,332	3,043	1,915	68.00
69.00	06900	ELECTROCARDIOLOGY	308,586	6,514	315,100	49,607	10,564	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	18,458	390	18,848	2,967	2,119	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	290,862	6,140	297,002	46,758	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	618,849	13,064	631,913	99,484	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,776,443	37,501	1,813,944	285,575	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	415,955	8,781	424,736	66,867	37,554	76.01
76.97	07697	CARDIAC REHABILITATION	210,916	4,452	215,368	33,906	25,452	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,163,314	130,098	6,293,412	990,771	0	88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	275,202	5,810	281,012	44,241	0	88.01
90.00	09000	CLINIC	694,361	14,658	709,019	111,623	277,563	90.00
90.01	04950	SLEEP LAB	145,143	3,064	148,207	23,333	23,682	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	160,697	3,392	164,089	25,833	33,317	90.03
91.00	09100	EMERGENCY	3,562,807	75,211	3,638,018	572,744	226,021	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,533,589	837,858	40,528,313	5,507,144	2,648,226	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	107,041	2,260	109,301	17,208	16,078	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,279	69	3,348	527	11,899	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	81,879	1,728	83,607	13,163	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	5,000	106	5,106	804	33,462	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	52,740	1,113	53,853	8,478	352,961	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
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)	40,783,528	843,134	40,783,528	5,547,324	3,062,626	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/22/2024 4:36 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	BUSINESS OFFICE						5.01
5.02	00591	A&G HOSPITAL-ONLY						5.02
5.03	00592	A&G SHARED						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	213,150					8.00
9.00	00900	HOUSEKEEPING	0	883,769				9.00
10.00	01000	DIETARY	0	1,334	1,095,103			10.00
11.00	01100	CAFETERIA	0	14,628	847,778	935,650		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	184	633,189	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,523	3,182	0	13,529	10,748	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,882	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	205	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	47,104	152,670	233,411	155,911	221,258	30.00
31.00	03100	INTENSIVE CARE UNIT	1,677	9,906	13,914	276	544	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	59,107	162,901	0	125,539	105,060	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	184	154	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,847	33,926	0	82,373	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	9,424	0	0	21,629	0	55.00
56.00	05600	RADIOISOTOPE	1,496	7,391	0	0	0	56.00
57.00	05700	CT SCAN	9,358	6,570	0	22,549	0	57.00
58.00	05800	MRI	6,706	5,820	0	11,873	0	58.00
60.00	06000	LABORATORY	0	21,680	0	115,231	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	8,879	0	44,362	0	65.00
66.00	06600	PHYSICAL THERAPY	4,647	19,247	0	65,623	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,381	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,266	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,104	0	70.00
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	7,391	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	7,309	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	7,237	0	15,094	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	634	132,346	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	195	0	0	0	0	88.01
90.00	09000	CLINIC	495	54,712	0	44,638	42,531	90.00
90.01	04950	SLEEP LAB	0	4,465	0	11,413	0	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	0	16,065	0	9,388	9,534	90.03
91.00	09100	EMERGENCY	58,937	87,775	0	175,053	243,360	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	213,150	771,521	1,095,103	931,600	633,189	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	955	0	4,050	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	0	0	0	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	4,096	0	0	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	107,197	0	0	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
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)	213,150	883,769	1,095,103	935,650	633,189	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/22/2024 4:36 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	BUSINESS OFFICE						5.01
5.02	00591	A&G HOSPITAL-ONLY						5.02
5.03	00592	A&G SHARED						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	232,910					14.00
15.00	01500	PHARMACY	685	955,453				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	128,741			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	376,824		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,705	0	2,817	362,523	4,351,287	30.00
31.00	03100	INTENSIVE CARE UNIT	438	0	149	14,301	236,570	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,044	0	13,930	0	4,206,808	50.00
53.00	05300	ANESTHESIOLOGY	2,596	0	1,554	0	182,385	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	159	0	6,513	0	2,452,457	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,929	0	2,890	0	533,128	55.00
56.00	05600	RADIOISOTOPE	135	0	958	0	289,625	56.00
57.00	05700	CT SCAN	3,425	0	18,259	0	960,034	57.00
58.00	05800	MRI	1,217	0	4,320	0	464,289	58.00
60.00	06000	LABORATORY	11,946	0	24,417	0	3,783,336	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	541	0	163,960	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,050	0	799,007	65.00
66.00	06600	PHYSICAL THERAPY	958	0	4,954	0	1,442,772	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	132	0	25,803	68.00
69.00	06900	ELECTROCARDIOLOGY	37	0	2,948	0	392,522	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	28	0	15	0	25,081	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	35,672	0	697	0	380,129	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	79,137	0	1,587	0	812,121	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,878	955,453	12,762	0	3,099,003	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	379	0	536,845	76.01
76.97	07697	CARDIAC REHABILITATION	289	0	613	0	297,959	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,060	0	9,207	0	7,430,430	88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	397	0	341	0	326,186	88.01
90.00	09000	CLINIC	9,869	0	1,677	0	1,252,127	90.00
90.01	04950	SLEEP LAB	2,236	0	663	0	213,999	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	1,766	0	1,000	0	260,992	90.03
91.00	09100	EMERGENCY	22,100	0	14,368	0	5,038,376	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	232,706	955,453	128,741	376,824	39,957,231	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	204	0	0	0	147,796	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	15,774	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	0	0	0	96,770	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	43,468	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	0	0	0	522,489	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	232,910	955,453	128,741	376,824	40,783,528	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part I | Date/Time Prepared: 2/22/2024 4:36 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	BUSINESS OFFICE				5.01
5.02	00591	A&G HOSPITAL-ONLY				5.02
5.03	00592	A&G SHARED				5.03
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	4,351,287		30.00
31.00	03100	INTENSIVE CARE UNIT	0	236,570		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,206,808		50.00
53.00	05300	ANESTHESIOLOGY	0	182,385		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,452,457		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	533,128		55.00
56.00	05600	RADIOISOTOPE	0	289,625		56.00
57.00	05700	CT SCAN	0	960,034		57.00
58.00	05800	MRI	0	464,289		58.00
60.00	06000	LABORATORY	0	3,783,336		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	163,960		63.00
65.00	06500	RESPIRATORY THERAPY	0	799,007		65.00
66.00	06600	PHYSICAL THERAPY	0	1,442,772		66.00
68.00	06800	SPEECH PATHOLOGY	0	25,803		68.00
69.00	06900	ELECTROCARDIOLOGY	0	392,522		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	25,081		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	380,129		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	812,121		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,099,003		73.00
76.00	03140	CARDIOLOGY	0	0		76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	536,845		76.01
76.97	07697	CARDIAC REHABILITATION	0	297,959		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	7,430,430		88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	0	326,186		88.01
90.00	09000	CLINIC	0	1,252,127		90.00
90.01	04950	SLEEP LAB	0	213,999		90.01
90.02	09001	GENERAL SURGERY CL	0	0		90.02
90.03	09002	PM PAIN CLINIC	0	260,992		90.03
91.00	09100	EMERGENCY	0	5,038,376		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	39,957,231		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	147,796		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,774		192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0		192.03
194.00	07956	WALNUT & HENRY CLINICS	0	96,770		194.00
194.01	07951	HOSPITAL LEASED SPACE	0	43,468		194.01
194.02	07950	PERRY HOME CARE - HHA	0	0		194.02
194.03	07953	MOB LEASED SPACE	0	522,489		194.03
194.05	07955	PERRY PLAZA LEASED	0	0		194.05
194.06	07954	PM PROMPT CARE	0	0		194.06
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	40,783,528		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/22/2024 4:36 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,793	0	2,793	2,793	4.00
5.01	00590	BUSINESS OFFICE	0	3,608	127	3,735	0	5.01
5.02	00591	A&G HOSPITAL-ONLY	0	29,020	106,256	135,276	67	5.02
5.03	00592	A&G SHARED	0	66,213	361,400	427,613	187	5.03
7.00	00700	OPERATION OF PLANT	0	227,311	201,430	428,741	65	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,992	0	2,992	7	8.00
9.00	00900	HOUSEKEEPING	0	6,210	3,856	10,066	76	9.00
10.00	01000	DIETARY	0	18,712	13,679	32,391	55	10.00
11.00	01100	CAFETERIA	0	9,302	0	9,302	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,426	0	8,426	11	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,674	8,797	15,471	11	14.00
15.00	01500	PHARMACY	0	7,094	19,417	26,511	60	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,173	1,452	16,625	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,264	0	2,264	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	72,345	26,903	99,248	282	30.00
31.00	03100	INTENSIVE CARE UNIT	0	12,936	11,859	24,795	8	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	72,085	211,764	283,849	228	50.00
53.00	05300	ANESTHESIOLOGY	0	650	70,375	71,025	1	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,434	253,877	267,311	120	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,240	25	1,265	43	55.00
56.00	05600	RADIOISOTOPE	0	3,200	0	3,200	0	56.00
57.00	05700	CT SCAN	0	3,634	1,344	4,978	32	57.00
58.00	05800	MRI	0	4,176	3,908	8,084	19	58.00
60.00	06000	LABORATORY	0	14,566	41,924	56,490	146	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	6,175	16,965	23,140	76	65.00
66.00	06600	PHYSICAL THERAPY	0	19,054	9,007	28,061	119	66.00
68.00	06800	SPEECH PATHOLOGY	0	286	0	286	2	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,578	14,610	16,188	22	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	317	3,162	3,479	1	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	5,611	0	5,611	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	3,803	7,709	11,512	29	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	129,957	129,957	680	88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	0	0	6,261	6,261	28	88.01
90.00	09000	CLINIC	0	41,474	6,538	48,012	76	90.00
90.01	04950	SLEEP LAB	0	3,539	1,393	4,932	15	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	0	4,978	10,404	15,382	14	90.03
91.00	09100	EMERGENCY	0	33,772	38,774	72,546	302	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	724,645	1,583,173	2,307,818	2,782	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,402	0	2,402	3	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,778	0	1,778	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	0	0	0	8	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	5,000	0	5,000	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	52,740	0	52,740	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	786,565	1,583,173	2,369,738	2,793	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/22/2024 4:36 pm

		Cost Center Description	BUSINESS OFFICE	A&G HOSPITAL-ONLY	A&G SHARED	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	BUSINESS OFFICE	3,735					5.01
5.02	00591	A&G HOSPITAL-ONLY	0	135,343				5.02
5.03	00592	A&G SHARED	0	18,411	446,211			5.03
7.00	00700	OPERATION OF PLANT	0	8,782	33,507	471,095		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	554	2,113	3,080	8,746	8.00
9.00	00900	HOUSEKEEPING	0	2,415	9,214	6,393	0	9.00
10.00	01000	DIETARY	0	2,777	10,596	19,263	0	10.00
11.00	01100	CAFETERIA	0	32	120	9,576	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,653	6,309	8,674	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	457	1,742	6,870	62	14.00
15.00	01500	PHARMACY	0	2,602	9,926	7,303	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	61	233	15,620	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,037	3,955	2,330	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	81	7,690	29,340	74,473	1,933	30.00
31.00	03100	INTENSIVE CARE UNIT	4	312	1,190	13,316	69	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	403	9,284	35,423	74,207	2,426	50.00
53.00	05300	ANESTHESIOLOGY	45	498	1,899	670	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	188	6,388	24,373	13,830	486	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	84	1,402	5,349	1,277	387	55.00
56.00	05600	RADIOISOTOPE	28	740	2,825	3,295	61	56.00
57.00	05700	CT SCAN	528	2,511	9,579	3,741	384	57.00
58.00	05800	MRI	125	1,165	4,446	4,299	275	58.00
60.00	06000	LABORATORY	720	10,072	38,430	14,995	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	16	469	1,788	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	30	2,017	7,695	6,357	0	65.00
66.00	06600	PHYSICAL THERAPY	143	3,498	13,346	19,615	191	66.00
68.00	06800	SPEECH PATHOLOGY	4	64	245	295	0	68.00
69.00	06900	ELECTROCARDIOLOGY	85	1,046	3,990	1,625	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	63	239	326	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20	986	3,761	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46	2,097	8,002	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	369	6,020	22,970	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	11	1,410	5,378	5,777	0	76.01
76.97	07697	CARDIAC REHABILITATION	18	715	2,727	3,915	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	266	20,871	79,710	0	26	88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	10	933	3,558	0	8	88.01
90.00	09000	CLINIC	48	2,353	8,978	42,695	20	90.00
90.01	04950	SLEEP LAB	19	492	1,877	3,643	0	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	29	545	2,078	5,125	0	90.03
91.00	09100	EMERGENCY	415	12,074	46,068	34,767	2,418	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,735	134,496	442,979	407,352	8,746	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	363	1,384	2,473	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11	42	1,830	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	277	1,059	0	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	17	65	5,147	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	179	682	54,293	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
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)	3,735	135,343	446,211	471,095	8,746	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/22/2024 4:36 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	BUSINESS OFFICE						5.01
5.02	00591	A&G HOSPITAL-ONLY						5.02
5.03	00592	A&G SHARED						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	28,164					9.00
10.00	01000	DIETARY	43	65,125				10.00
11.00	01100	CAFETERIA	466	50,417	69,913			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	14	25,087		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	101	0	1,011	426	26,151	14.00
15.00	01500	PHARMACY	0	0	0	0	77	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	187	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	7	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,865	13,881	11,650	8,766	1,090	30.00
31.00	03100	INTENSIVE CARE UNIT	316	827	21	22	49	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,191	0	9,380	4,162	2,251	50.00
53.00	05300	ANESTHESIOLOGY	0	0	14	6	291	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,081	0	6,155	0	18	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	1,616	0	217	55.00
56.00	05600	RADIOISOTOPE	236	0	0	0	15	56.00
57.00	05700	CT SCAN	209	0	1,685	0	385	57.00
58.00	05800	MRI	185	0	887	0	137	58.00
60.00	06000	LABORATORY	691	0	8,610	0	1,341	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	283	0	3,315	0	0	65.00
66.00	06600	PHYSICAL THERAPY	613	0	4,903	0	108	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	103	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,066	0	4	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	83	0	3	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	4,005	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	8,885	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	236	0	0	0	2,681	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	233	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	231	0	1,128	0	32	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,218	0	0	0	456	88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	0	0	0	0	45	88.01
90.00	09000	CLINIC	1,744	0	3,335	1,685	1,108	90.00
90.01	04950	SLEEP LAB	142	0	853	0	251	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	512	0	701	378	198	90.03
91.00	09100	EMERGENCY	2,797	0	13,080	9,642	2,481	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,587	65,125	69,610	25,087	26,128	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	30	0	303	0	23	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	0	0	0	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	131	0	0	0	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	3,416	0	0	0	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
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)	28,164	65,125	69,913	25,087	26,151	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II Date/Time Prepared: 2/22/2024 4:36 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	BUSINESS OFFICE						5.01
5.02	00591	A&G HOSPITAL-ONLY						5.02
5.03	00592	A&G SHARED						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	46,479					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	32,726				16.00
17.00	01700	SOCIAL SERVICE	0	0	9,593			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	717	9,229	263,245	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	38	364	41,331	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,543	0	430,347	0	50.00
53.00	05300	ANESTHESIOLOGY	0	395	0	74,844	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,656	0	321,606	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	735	0	12,375	0	55.00
56.00	05600	RADIOISOTOPE	0	244	0	10,644	0	56.00
57.00	05700	CT SCAN	0	4,644	0	28,676	0	57.00
58.00	05800	MRI	0	1,099	0	20,721	0	58.00
60.00	06000	LABORATORY	0	6,191	0	137,686	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	138	0	2,411	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	267	0	43,180	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,260	0	71,857	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	34	0	1,033	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	750	0	24,776	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4	0	4,198	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	177	0	8,949	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	404	0	19,434	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	46,479	3,246	0	82,001	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	96	0	18,516	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	156	0	20,463	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,342	0	238,526	0	88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	0	87	0	10,930	0	88.01
90.00	09000	CLINIC	0	426	0	110,480	0	90.00
90.01	04950	SLEEP LAB	0	169	0	12,393	0	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	0	254	0	25,216	0	90.03
91.00	09100	EMERGENCY	0	3,654	0	200,244	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,479	32,726	9,593	2,236,082	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	6,981	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	3,661	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	0	0	1,344	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	10,360	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	0	0	111,310	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
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)	46,479	32,726	9,593	2,369,738	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B Part II | Date/Time Prepared: 2/22/2024 4:36 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00590	BUSINESS OFFICE			5.01
5.02	00591	A&G HOSPITAL-ONLY			5.02
5.03	00592	A&G SHARED			5.03
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	263,245		30.00
31.00	03100	INTENSIVE CARE UNIT	41,331		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	430,347		50.00
53.00	05300	ANESTHESIOLOGY	74,844		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	321,606		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,375		55.00
56.00	05600	RADIOISOTOPE	10,644		56.00
57.00	05700	CT SCAN	28,676		57.00
58.00	05800	MRI	20,721		58.00
60.00	06000	LABORATORY	137,686		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,411		63.00
65.00	06500	RESPIRATORY THERAPY	43,180		65.00
66.00	06600	PHYSICAL THERAPY	71,857		66.00
68.00	06800	SPEECH PATHOLOGY	1,033		68.00
69.00	06900	ELECTROCARDIOLOGY	24,776		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,198		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,949		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,434		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	82,001		73.00
76.00	03140	CARDIOLOGY	0		76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	18,516		76.01
76.97	07697	CARDIAC REHABILITATION	20,463		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	238,526		88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	10,930		88.01
90.00	09000	CLINIC	110,480		90.00
90.01	04950	SLEEP LAB	12,393		90.01
90.02	09001	GENERAL SURGERY CL	0		90.02
90.03	09002	PM PAIN CLINIC	25,216		90.03
91.00	09100	EMERGENCY	200,244		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,236,082		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,981		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,661		192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0		192.03
194.00	07956	WALNUT & HENRY CLINICS	1,344		194.00
194.01	07951	HOSPITAL LEASED SPACE	10,360		194.01
194.02	07950	PERRY HOME CARE - HHA	0		194.02
194.03	07953	MOB LEASED SPACE	111,310		194.03
194.05	07955	PERRY PLAZA LEASED	0		194.05
194.06	07954	PM PROMPT CARE	0		194.06
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,369,738		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/22/2024 4:36 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	BUSINESS OFFICE (GROSS REVENUE)	Reconciliation	
			1.00	2.00	4.00	5.01	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	181,384					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,124,044				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	644	0	15,301,992			4.00
5.01	00590	BUSINESS OFFICE	832	90	0	124,059,830		5.01
5.02	00591	A&G HOSPITAL-ONLY	6,692	75,441	365,317	0	-843,134	5.02
5.03	00592	A&G SHARED	15,269	256,592	1,024,211	0	0	5.03
7.00	00700	OPERATION OF PLANT	52,418	143,014	355,338	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	690	0	38,561	0	0	8.00
9.00	00900	HOUSEKEEPING	1,432	2,738	415,059	0	0	9.00
10.00	01000	DIETARY	4,315	9,712	299,240	0	0	10.00
11.00	01100	CAFETERIA	2,145	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,943	0	57,925	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,539	6,246	62,233	0	0	14.00
15.00	01500	PHARMACY	1,636	13,786	326,602	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,499	1,031	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	522	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,683	19,101	1,542,572	2,714,261	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,983	8,420	43,839	143,085	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,623	150,351	1,245,112	13,419,601	0	50.00
53.00	05300	ANESTHESIOLOGY	150	49,966	5,500	1,497,497	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,098	180,251	656,300	6,274,331	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	286	18	236,280	2,784,588	0	55.00
56.00	05600	RADIOISOTOPE	738	0	0	922,683	0	56.00
57.00	05700	CT SCAN	838	954	172,445	17,590,222	0	57.00
58.00	05800	MRI	963	2,775	103,235	4,162,051	0	58.00
60.00	06000	LABORATORY	3,359	29,766	800,458	23,555,228	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	521,171	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,424	12,045	413,049	1,011,843	0	65.00
66.00	06600	PHYSICAL THERAPY	4,394	6,395	652,018	4,772,883	0	66.00
68.00	06800	SPEECH PATHOLOGY	66	0	11,430	127,269	0	68.00
69.00	06900	ELECTROCARDIOLOGY	364	10,373	117,678	2,839,865	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	73	2,245	6,889	13,998	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	671,851	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,528,781	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,294,552	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	1,294	0	0	365,019	0	76.01
76.97	07697	CARDIAC REHABILITATION	877	5,473	160,873	590,857	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	92,269	3,744,756	8,870,295	0	88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	0	4,445	154,775	328,059	0	88.01
90.00	09000	CLINIC	9,564	4,642	416,851	1,615,314	0	90.00
90.01	04950	SLEEP LAB	816	989	84,376	638,825	0	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	1,148	7,387	76,154	963,367	0	90.03
91.00	09100	EMERGENCY	7,788	27,529	1,652,552	13,842,334	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	167,105	1,124,044	15,241,628	124,059,830	-843,134	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	554	0	15,535	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	410	0	0	0	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	0	44,829	0	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	1,153	0	0	0	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	12,162	0	0	0	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
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)	786,565	1,583,173	472,377	3,170,911		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.336463	1.408462	0.030870	0.025560		203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/22/2024 4:36 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	BUSINESS OFFICE (GROSS REVENUE)	Reconciliation	
			1.00	2.00	4.00	5.01	5A.02	
204.00		Cost to be allocated (per Wkst. B, Part II)			2,793	3,735		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000183	0.000030		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: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/22/2024 4:36 pm

		Cost Center Description	A&G HOSPITAL-ONLY (ACCUM. COST)	Reconciliation	A&G SHARED (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5.02	5A.03	5.03	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	BUSINESS OFFICE						5.01
5.02	00591	A&G HOSPITAL-ONLY	39,940,394					5.02
5.03	00592	A&G SHARED	5,432,641	-5,547,324	35,236,204			5.03
7.00	00700	OPERATION OF PLANT	2,591,347	0	2,646,050	105,529		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	163,406	0	166,856	690	128,765	8.00
9.00	00900	HOUSEKEEPING	712,610	0	727,653	1,432	0	9.00
10.00	01000	DIETARY	819,501	0	836,801	4,315	0	10.00
11.00	01100	CAFETERIA	9,302	0	9,498	2,145	0	11.00
13.00	01300	NURSING ADMINISTRATION	487,886	0	498,185	1,943	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	134,756	0	137,601	1,539	920	14.00
15.00	01500	PHARMACY	767,674	0	783,880	1,636	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,032	0	18,413	3,499	0	16.00
17.00	01700	SOCIAL SERVICE	305,847	0	312,303	522	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,269,054	0	2,316,954	16,683	28,456	30.00
31.00	03100	INTENSIVE CARE UNIT	92,052	0	93,995	2,983	1,013	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,739,565	0	2,797,397	16,623	35,707	50.00
53.00	05300	ANESTHESIOLOGY	146,839	0	149,939	150	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,884,925	0	1,924,716	3,098	7,157	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	413,715	0	422,449	286	5,693	55.00
56.00	05600	RADIOISOTOPE	218,491	0	223,103	738	904	56.00
57.00	05700	CT SCAN	740,822	0	756,461	838	5,653	57.00
58.00	05800	MRI	343,867	0	351,126	963	4,051	58.00
60.00	06000	LABORATORY	2,972,060	0	3,034,800	3,359	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	138,272	0	141,191	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	595,151	0	607,715	1,424	0	65.00
66.00	06600	PHYSICAL THERAPY	1,032,115	0	1,053,903	4,394	2,807	66.00
68.00	06800	SPEECH PATHOLOGY	18,932	0	19,332	66	0	68.00
69.00	06900	ELECTROCARDIOLOGY	308,586	0	315,100	364	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	18,458	0	18,848	73	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	290,862	0	297,002	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	618,849	0	631,913	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,776,443	0	1,813,944	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	415,955	0	424,736	1,294	0	76.01
76.97	07697	CARDIAC REHABILITATION	210,916	0	215,368	877	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,163,314	0	6,293,412	0	383	88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	275,202	0	281,012	0	118	88.01
90.00	09000	CLINIC	694,361	0	709,019	9,564	299	90.00
90.01	04950	SLEEP LAB	145,143	0	148,207	816	0	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	160,697	0	164,089	1,148	0	90.03
91.00	09100	EMERGENCY	3,562,807	0	3,638,018	7,788	35,604	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,690,455	-5,547,324	34,980,989	91,250	128,765	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	107,041	0	109,301	554	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,279	0	3,348	410	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	81,879	0	83,607	0	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	5,000	0	5,106	1,153	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	52,740	0	53,853	12,162	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
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)	843,134		5,547,324	3,062,626	213,150	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.021110		0.157433	29.021653	1.655341	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	135,343		446,211	471,095	8,746	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003389		0.012663	4.464128	0.067922	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/22/2024 4:36 pm

		Cost Center Description	A&G HOSPITAL-ONLY (ACCUM. COST)	Reconciliation	A&G SHARED (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5.02	5A.03	5.03	7.00	8.00	
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: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/22/2024 4:36 pm

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	BUSINESS OFFICE						5.01
5.02	00591	A&G HOSPITAL-ONLY						5.02
5.03	00592	A&G SHARED						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	86,096					9.00
10.00	01000	DIETARY	130	23,454				10.00
11.00	01100	CAFETERIA	1,425	18,157	10,166			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2	180,452		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	310	0	147	3,063	1,706,332	14.00
15.00	01500	PHARMACY	0	0	0	0	5,022	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	573	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	20	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,873	4,999	1,694	63,056	71,102	30.00
31.00	03100	INTENSIVE CARE UNIT	965	298	3	155	3,207	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,870	0	1,364	29,941	146,846	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2	44	19,018	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,305	0	895	0	1,164	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	235	0	14,130	55.00
56.00	05600	RADIOISOTOPE	720	0	0	0	987	56.00
57.00	05700	CT SCAN	640	0	245	0	25,094	57.00
58.00	05800	MRI	567	0	129	0	8,914	58.00
60.00	06000	LABORATORY	2,112	0	1,252	0	87,517	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	865	0	482	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,875	0	713	0	7,022	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	15	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	155	0	270	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	12	0	202	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	261,339	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	579,773	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	720	0	0	0	174,933	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	712	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	705	0	164	0	2,117	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	12,893	0	0	0	29,743	88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	0	0	0	0	2,910	88.01
90.00	09000	CLINIC	5,330	0	485	12,121	72,304	90.00
90.01	04950	SLEEP LAB	435	0	124	0	16,384	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	1,565	0	102	2,717	12,936	90.03
91.00	09100	EMERGENCY	8,551	0	1,902	69,355	161,905	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,161	23,454	10,122	180,452	1,704,839	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	93	0	44	0	1,493	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	WALNUT & HENRY CLINICS	0	0	0	0	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	399	0	0	0	0	194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	10,443	0	0	0	0	194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	0	194.05
194.06	07954	PM PROMPT CARE	0	0	0	0	0	194.06
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)	883,769	1,095,103	935,650	633,189	232,910	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.264925	46.691524	92.037183	3.508905	0.136497	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	28,164	65,125	69,913	25,087	26,151	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.327123	2.776712	6.877139	0.139023	0.015326	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/22/2024 4:36 pm

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
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: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/22/2024 4:36 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)		
			15.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	BUSINESS OFFICE					5.01
5.02	00591	A&G HOSPITAL-ONLY					5.02
5.03	00592	A&G SHARED					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	124,059,830			16.00
17.00	01700	SOCIAL SERVICE	0	0	1,133		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	2,714,261	1,090		30.00
31.00	03100	INTENSIVE CARE UNIT	0	143,085	43		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	13,419,601	0		50.00
53.00	05300	ANESTHESIOLOGY	0	1,497,497	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,274,331	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,784,588	0		55.00
56.00	05600	RADIOISOTOPE	0	922,683	0		56.00
57.00	05700	CT SCAN	0	17,590,222	0		57.00
58.00	05800	MRI	0	4,162,051	0		58.00
60.00	06000	LABORATORY	0	23,555,228	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	521,171	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	1,011,843	0		65.00
66.00	06600	PHYSICAL THERAPY	0	4,772,883	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	127,269	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,839,865	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	13,998	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	671,851	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,528,781	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	12,294,552	0		73.00
76.00	03140	CARDIOLOGY	0	0	0		76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	365,019	0		76.01
76.97	07697	CARDIAC REHABILITATION	0	590,857	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	8,870,295	0		88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	0	328,059	0		88.01
90.00	09000	CLINIC	0	1,615,314	0		90.00
90.01	04950	SLEEP LAB	0	638,825	0		90.01
90.02	09001	GENERAL SURGERY CL	0	0	0		90.02
90.03	09002	PM PAIN CLINIC	0	963,367	0		90.03
91.00	09100	EMERGENCY	0	13,842,334	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	124,059,830	1,133		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0		192.03
194.00	07956	WALNUT & HENRY CLINICS	0	0	0		194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	0		194.01
194.02	07950	PERRY HOME CARE - HHA	0	0	0		194.02
194.03	07953	MOB LEASED SPACE	0	0	0		194.03
194.05	07955	PERRY PLAZA LEASED	0	0	0		194.05
194.06	07954	PM PROMPT CARE	0	0	0		194.06
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)	955,453	128,741	376,824		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9,554.530000	0.001038	332.589585		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	46,479	32,726	9,593		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	464.790000	0.000264	8.466902		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet B-1 | Date/Time Prepared: 2/22/2024 4:36 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)		
			15.00	16.00	17.00		
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: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/22/2024 4:36 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	4,351,287		4,351,287	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	236,570		236,570	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,206,808		4,206,808	0	0	50.00
53.00	05300	ANESTHESIOLOGY	182,385		182,385	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,452,457		2,452,457	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	533,128		533,128	0	0	55.00
56.00	05600	RADIOISOTOPE	289,625		289,625	0	0	56.00
57.00	05700	CT SCAN	960,034		960,034	0	0	57.00
58.00	05800	MRI	464,289		464,289	0	0	58.00
60.00	06000	LABORATORY	3,783,336		3,783,336	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	163,960		163,960	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	799,007	0	799,007	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,442,772	0	1,442,772	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	25,803	0	25,803	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	392,522		392,522	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	25,081		25,081	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	380,129		380,129	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	812,121		812,121	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,099,003		3,099,003	0	0	73.00
76.00	03140	CARDIOLOGY	0		0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	536,845		536,845	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	297,959		297,959	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,430,430		7,430,430	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	326,186		326,186	0	0	88.01
90.00	09000	CLINIC	1,252,127		1,252,127	0	0	90.00
90.01	04950	SLEEP LAB	213,999		213,999	0	0	90.01
90.02	09001	GENERAL SURGERY CL	0		0	0	0	90.02
90.03	09002	PM PAIN CLINIC	260,992		260,992	0	0	90.03
91.00	09100	EMERGENCY	5,038,376		5,038,376	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,722,789		1,722,789		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	41,680,020	0	41,680,020	0	0	200.00
201.00		Less Observation Beds	1,722,789		1,722,789		0	201.00
202.00		Total (see instructions)	39,957,231	0	39,957,231	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/22/2024 4:36 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	1,698,299		1,698,299			30.00
31.00	03100	INTENSIVE CARE UNIT	143,085		143,085			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	306,258	13,114,429	13,420,687	0.313457	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	30,546	1,466,950	1,497,496	0.121793	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	119,648	6,154,683	6,274,331	0.390871	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	46,217	2,738,371	2,784,588	0.191457	0.000000	55.00
56.00	05600	RADIOISOTOPE	4,900	917,783	922,683	0.313894	0.000000	56.00
57.00	05700	CT SCAN	582,814	17,007,409	17,590,223	0.054578	0.000000	57.00
58.00	05800	MRI	85,436	4,076,615	4,162,051	0.111553	0.000000	58.00
60.00	06000	LABORATORY	973,088	22,582,140	23,555,228	0.160616	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	49,904	470,181	520,085	0.315256	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	359,999	651,844	1,011,843	0.789655	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	271,969	4,500,914	4,772,883	0.302285	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	5,163	122,106	127,269	0.202744	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	122,146	2,717,719	2,839,865	0.138219	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	13,998	13,998	1.791756	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,548	655,303	671,851	0.565794	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,598	1,504,183	1,528,781	0.531221	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	536,149	11,760,094	12,296,243	0.252028	0.000000	73.00
76.00	03140	CARDIOLOGY	0	0	0	0.000000	0.000000	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	365,019	365,019	1.470732	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	590,857	590,857	0.504283	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	8,870,295	8,870,295			88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	0	328,059	328,059			88.01
90.00	09000	CLINIC	72	1,612,057	1,612,129	0.776692	0.000000	90.00
90.01	04950	SLEEP LAB	833	637,992	638,825	0.334988	0.000000	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	0.000000	0.000000	90.02
90.03	09002	PM PAIN CLINIC	0	963,367	963,367	0.270916	0.000000	90.03
91.00	09100	EMERGENCY	337,939	13,509,399	13,847,338	0.363852	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	87,122	928,840	1,015,962	1.695722	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,802,733	118,260,607	124,063,340			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,802,733	118,260,607	124,063,340			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/22/2024 4:36 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
31.00	03100	INTENSIVE CARE UNIT		31.00
		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
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03140	CARDIOLOGY	0.000000	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY		88.01
90.00	09000	CLINIC	0.000000	90.00
90.01	04950	SLEEP LAB	0.000000	90.01
90.02	09001	GENERAL SURGERY CL	0.000000	90.02
90.03	09002	PM PAIN CLINIC	0.000000	90.03
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/22/2024 4:36 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	4,351,287		4,351,287	0	4,351,287	30.00
31.00	03100	INTENSIVE CARE UNIT	236,570		236,570	0	236,570	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,206,808		4,206,808	0	4,206,808	50.00
53.00	05300	ANESTHESIOLOGY	182,385		182,385	0	182,385	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,452,457		2,452,457	0	2,452,457	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	533,128		533,128	0	533,128	55.00
56.00	05600	RADIOISOTOPE	289,625		289,625	0	289,625	56.00
57.00	05700	CT SCAN	960,034		960,034	0	960,034	57.00
58.00	05800	MRI	464,289		464,289	0	464,289	58.00
60.00	06000	LABORATORY	3,783,336		3,783,336	0	3,783,336	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	163,960		163,960	0	163,960	63.00
65.00	06500	RESPIRATORY THERAPY	799,007	0	799,007	0	799,007	65.00
66.00	06600	PHYSICAL THERAPY	1,442,772	0	1,442,772	0	1,442,772	66.00
68.00	06800	SPEECH PATHOLOGY	25,803	0	25,803	0	25,803	68.00
69.00	06900	ELECTROCARDIOLOGY	392,522		392,522	0	392,522	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	25,081		25,081	0	25,081	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	380,129		380,129	0	380,129	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	812,121		812,121	0	812,121	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,099,003		3,099,003	0	3,099,003	73.00
76.00	03140	CARDIOLOGY	0		0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	536,845		536,845	0	536,845	76.01
76.97	07697	CARDIAC REHABILITATION	297,959		297,959	0	297,959	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,430,430		7,430,430	0	7,430,430	88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	326,186		326,186	0	326,186	88.01
90.00	09000	CLINIC	1,252,127		1,252,127	0	1,252,127	90.00
90.01	04950	SLEEP LAB	213,999		213,999	0	213,999	90.01
90.02	09001	GENERAL SURGERY CL	0		0	0	0	90.02
90.03	09002	PM PAIN CLINIC	260,992		260,992	0	260,992	90.03
91.00	09100	EMERGENCY	5,038,376		5,038,376	0	5,038,376	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,722,789		1,722,789		1,722,789	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	41,680,020	0	41,680,020	0	41,680,020	200.00
201.00		Less Observation Beds	1,722,789		1,722,789		1,722,789	201.00
202.00		Total (see instructions)	39,957,231	0	39,957,231	0	39,957,231	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/22/2024 4:36 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	1,698,299		1,698,299			30.00
31.00	03100	INTENSIVE CARE UNIT	143,085		143,085			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	306,258	13,114,429	13,420,687	0.313457	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	30,546	1,466,950	1,497,496	0.121793	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	119,648	6,154,683	6,274,331	0.390871	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	46,217	2,738,371	2,784,588	0.191457	0.000000	55.00
56.00	05600	RADIOISOTOPE	4,900	917,783	922,683	0.313894	0.000000	56.00
57.00	05700	CT SCAN	582,814	17,007,409	17,590,223	0.054578	0.000000	57.00
58.00	05800	MRI	85,436	4,076,615	4,162,051	0.111553	0.000000	58.00
60.00	06000	LABORATORY	973,088	22,582,140	23,555,228	0.160616	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	49,904	470,181	520,085	0.315256	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	359,999	651,844	1,011,843	0.789655	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	271,969	4,500,914	4,772,883	0.302285	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	5,163	122,106	127,269	0.202744	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	122,146	2,717,719	2,839,865	0.138219	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	13,998	13,998	1.791756	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,548	655,303	671,851	0.565794	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,598	1,504,183	1,528,781	0.531221	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	536,149	11,760,094	12,296,243	0.252028	0.000000	73.00
76.00	03140	CARDIOLOGY	0	0	0	0.000000	0.000000	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	365,019	365,019	1.470732	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	590,857	590,857	0.504283	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	8,870,295	8,870,295	0.837676	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	0	328,059	328,059	0.994291	0.000000	88.01
90.00	09000	CLINIC	72	1,612,057	1,612,129	0.776692	0.000000	90.00
90.01	04950	SLEEP LAB	833	637,992	638,825	0.334988	0.000000	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	0.000000	0.000000	90.02
90.03	09002	PM PAIN CLINIC	0	963,367	963,367	0.270916	0.000000	90.03
91.00	09100	EMERGENCY	337,939	13,509,399	13,847,338	0.363852	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	87,122	928,840	1,015,962	1.695722	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,802,733	118,260,607	124,063,340			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,802,733	118,260,607	124,063,340			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet C Part I Date/Time Prepared: 2/22/2024 4:36 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
31.00	03100	INTENSIVE CARE UNIT			31.00
		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
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03140	CARDIOLOGY	0.000000		76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0.000000		76.01
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	0.000000		88.01
90.00	09000	CLINIC	0.000000		90.00
90.01	04950	SLEEP LAB	0.000000		90.01
90.02	09001	GENERAL SURGERY CL	0.000000		90.02
90.03	09002	PM PAIN CLINIC	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part II Date/Time Prepared: 2/22/2024 4:36 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	430,347	13,420,687	0.032066	76,693	2,459	50.00
53.00	05300	ANESTHESIOLOGY	74,844	1,497,496	0.049979	9,112	455	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	321,606	6,274,331	0.051257	40,400	2,071	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,375	2,784,588	0.004444	21,113	94	55.00
56.00	05600	RADIOISOTOPE	10,644	922,683	0.011536	4,900	57	56.00
57.00	05700	CT SCAN	28,676	17,590,223	0.001630	182,501	297	57.00
58.00	05800	MRI	20,721	4,162,051	0.004979	38,942	194	58.00
60.00	06000	LABORATORY	137,686	23,555,228	0.005845	367,208	2,146	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,411	520,085	0.004636	17,374	81	63.00
65.00	06500	RESPIRATORY THERAPY	43,180	1,011,843	0.042675	178,699	7,626	65.00
66.00	06600	PHYSICAL THERAPY	71,857	4,772,883	0.015055	126,115	1,899	66.00
68.00	06800	SPEECH PATHOLOGY	1,033	127,269	0.008117	3,032	25	68.00
69.00	06900	ELECTROCARDIOLOGY	24,776	2,839,865	0.008724	49,242	430	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,198	13,998	0.299900	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,949	671,851	0.013320	1,077	14	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,434	1,528,781	0.012712	1,905	24	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	82,001	12,296,243	0.006669	232,620	1,551	73.00
76.00	03140	CARDIOLOGY	0	0	0.000000	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	18,516	365,019	0.050726	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	20,463	590,857	0.034633	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	238,526	8,870,295	0.026890	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	10,930	328,059	0.033317	0	0	88.01
90.00	09000	CLINIC	110,480	1,612,129	0.068530	0	0	90.00
90.01	04950	SLEEP LAB	12,393	638,825	0.019400	0	0	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0.000000	0	0	90.02
90.03	09002	PM PAIN CLINIC	25,216	963,367	0.026175	0	0	90.03
91.00	09100	EMERGENCY	200,244	13,847,338	0.014461	7,149	103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	104,225	1,015,962	0.102587	2,377	244	92.00
200.00		Total (lines 50 through 199)	2,035,731	122,221,956		1,360,459	19,770	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/22/2024 4:36 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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	SLEEP LAB	0	0	0	0	0	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	0	0	0	0	0	90.03
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: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/22/2024 4:36 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	13,420,687	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,497,496	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,274,331	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	2,784,588	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	922,683	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	17,590,223	0.000000	57.00
58.00	05800	MRI	0	0	0	4,162,051	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	23,555,228	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	520,085	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,011,843	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,772,883	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	127,269	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,839,865	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	13,998	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	671,851	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,528,781	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,296,243	0.000000	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0.000000	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0	0	0	365,019	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	590,857	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	8,870,295	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	0	0	0	328,059	0.000000	88.01
90.00	09000	CLINIC	0	0	0	1,612,129	0.000000	90.00
90.01	04950	SLEEP LAB	0	0	0	638,825	0.000000	90.01
90.02	09001	GENERAL SURGERY CL	0	0	0	0	0.000000	90.02
90.03	09002	PM PAIN CLINIC	0	0	0	963,367	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	13,847,338	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,015,962	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	122,221,956		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part IV Date/Time Prepared: 2/22/2024 4:36 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	76,693	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	9,112	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	40,400	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	21,113	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	4,900	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	182,501	0	0	0	57.00
58.00	05800	MRI	0.000000	38,942	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	367,208	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	17,374	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	178,699	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	126,115	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	3,032	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	49,242	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,077	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,905	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	232,620	0	0	0	73.00
76.00	03140	CARDIOLOGY	0.000000	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	SLEEP LAB	0.000000	0	0	0	0	90.01
90.02	09001	GENERAL SURGERY CL	0.000000	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	7,149	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,377	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,360,459	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/22/2024 4:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.313457	0	4,099,390	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.121793	0	481,183	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.390871	0	1,751,580	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.191457	0	846,795	0	0	55.00
56.00	05600	RADIOISOTOPE	0.313894	0	393,843	0	0	56.00
57.00	05700	CT SCAN	0.054578	0	6,251,664	0	0	57.00
58.00	05800	MRI	0.111553	0	1,245,172	0	0	58.00
60.00	06000	LABORATORY	0.160616	0	7,926,625	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.315256	0	244,211	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.789655	0	266,133	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.302285	0	1,638,028	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.202744	0	43,836	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.138219	0	1,064,143	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.791756	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.565794	0	197,514	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.531221	0	314,038	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252028	0	6,882,048	1,606	0	73.00
76.00	03140	CARDIOLOGY	0.000000	0	0	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	1.470732	0	237,171	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.504283	0	272,208	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY						88.01
90.00	09000	CLINIC	0.776692	0	931,610	0	0	90.00
90.01	04950	SLEEP LAB	0.334988	0	152,713	0	0	90.01
90.02	09001	GENERAL SURGERY CL	0.000000	0	0	0	0	90.02
90.03	09002	PM PAIN CLINIC	0.270916	0	390,901	0	0	90.03
91.00	09100	EMERGENCY	0.363852	0	4,038,383	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.695722	0	437,974	0	0	92.00
200.00		Subtotal (see instructions)		0	40,107,163	1,606	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	40,107,163	1,606	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D Part V Date/Time Prepared: 2/22/2024 4:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,284,982	0		50.00
53.00	05300	ANESTHESIOLOGY	58,605	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	684,642	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	162,125	0		55.00
56.00	05600	RADIOISOTOPE	123,625	0		56.00
57.00	05700	CT SCAN	341,203	0		57.00
58.00	05800	MRI	138,903	0		58.00
60.00	06000	LABORATORY	1,273,143	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	76,989	0		63.00
65.00	06500	RESPIRATORY THERAPY	210,153	0		65.00
66.00	06600	PHYSICAL THERAPY	495,151	0		66.00
68.00	06800	SPEECH PATHOLOGY	8,887	0		68.00
69.00	06900	ELECTROCARDIOLOGY	147,085	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	111,752	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	166,824	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,734,469	405		73.00
76.00	03140	CARDIOLOGY	0	0		76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	348,815	0		76.01
76.97	07697	CARDIAC REHABILITATION	137,270	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY				88.01
90.00	09000	CLINIC	723,574	0		90.00
90.01	04950	SLEEP LAB	51,157	0		90.01
90.02	09001	GENERAL SURGERY CL	0	0		90.02
90.03	09002	PM PAIN CLINIC	105,901	0		90.03
91.00	09100	EMERGENCY	1,469,374	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	742,682	0		92.00
200.00		Subtotal (see instructions)	10,597,311	405		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	10,597,311	405		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1337	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/22/2024 4:36 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)		1,834	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,732	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.	do	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,016	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		26	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)		48	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		1	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)		27	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		584	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)		15	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)		49	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
	SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		188.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		208.70	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,351,287	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)	5	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)	x	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)	x	188	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)	x	5,635	25.00
26.00	Total swing-bed cost (see instructions)		183,877	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,167,410	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 minus line 36)	27	4,167,410	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)		2,406.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,405,180	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,405,180	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/22/2024 4:36 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	236,570	43	5,501.63	19	104,531	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	378,817	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)	1,888,528	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)	36,092	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	117,900	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	153,992	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)	716	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,406.13	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,722,789	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-1 | Date/Time Prepared: 2/22/2024 4:36 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	263,245	4,351,287	0.060498	1,722,789	104,225	90.00
91.00	Nursing Program cost	0	4,351,287	0.000000	1,722,789	0	91.00
92.00	Allied health cost	0	4,351,287	0.000000	1,722,789	0	92.00
93.00	All other Medical Education	0	4,351,287	0.000000	1,722,789	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/22/2024 4:36 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		895,711		30.00
31.00	03100	INTENSIVE CARE UNIT		61,894		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.313457	76,693	24,040	50.00
53.00	05300	ANESTHESIOLOGY	0.121793	9,112	1,110	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.390871	40,400	15,791	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.191457	21,113	4,042	55.00
56.00	05600	RADIOISOTOPE	0.313894	4,900	1,538	56.00
57.00	05700	CT SCAN	0.054578	182,501	9,961	57.00
58.00	05800	MRI	0.111553	38,942	4,344	58.00
60.00	06000	LABORATORY	0.160616	367,208	58,979	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.315256	17,374	5,477	63.00
65.00	06500	RESPIRATORY THERAPY	0.789655	178,699	141,111	65.00
66.00	06600	PHYSICAL THERAPY	0.302285	126,115	38,123	66.00
68.00	06800	SPEECH PATHOLOGY	0.202744	3,032	615	68.00
69.00	06900	ELECTROCARDIOLOGY	0.138219	49,242	6,806	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.791756	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.565794	1,077	609	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.531221	1,905	1,012	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252028	232,620	58,627	73.00
76.00	03140	CARDIOLOGY	0.000000	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	1.470732	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.504283	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	0.000000		0	88.01
90.00	09000	CLINIC	0.776692	0	0	90.00
90.01	04950	SLEEP LAB	0.334988	0	0	90.01
90.02	09001	GENERAL SURGERY CL	0.000000	0	0	90.02
90.03	09002	PM PAIN CLINIC	0.270916	0	0	90.03
91.00	09100	EMERGENCY	0.363852	7,149	2,601	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.695722	2,377	4,031	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,360,459	378,817	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)		1,360,459		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1337 | Component CCN: 14-Z337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet D-3 | Date/Time Prepared: 2/22/2024 4:36 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
31.00	03100	INTENSIVE CARE UNIT				31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.313457	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.121793	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.390871	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.191457	0	0	55.00
56.00	05600	RADIOISOTOPE	0.313894	0	0	56.00
57.00	05700	CT SCAN	0.054578	0	0	57.00
58.00	05800	MRI	0.111553	0	0	58.00
60.00	06000	LABORATORY	0.160616	7,048	1,132	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.315256	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.789655	7,872	6,216	65.00
66.00	06600	PHYSICAL THERAPY	0.302285	26,450	7,995	66.00
68.00	06800	SPEECH PATHOLOGY	0.202744	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.138219	2,492	344	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.791756	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.565794	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.531221	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252028	25,094	6,324	73.00
76.00	03140	CARDIOLOGY	0.000000	0	0	76.00
76.01	03950	SENIOR BEHAVIORAL WELLNESS	1.470732	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.504283	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC - HENRY	0.000000		0	88.01
90.00	09000	CLINIC	0.776692	0	0	90.00
90.01	04950	SLEEP LAB	0.334988	0	0	90.01
90.02	09001	GENERAL SURGERY CL	0.000000	0	0	90.02
90.03	09002	PM PAIN CLINIC	0.270916	0	0	90.03
91.00	09100	EMERGENCY	0.363852	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.695722	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		68,956	22,011	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)		68,956		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1337	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/22/2024 4:36 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	10,597,716	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	10,597,716	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)	10,703,693	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)	68,933	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	6,232,933	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	4,401,827	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	4,401,827	30.00
31.00	Primary payer payments	2,229	31.00
32.00	Subtotal (line 30 minus line 31)	4,399,598	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)	367,774	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	239,053	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	356,042	36.00
37.00	Subtotal (see instructions)	4,638,651	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,638,651	40.00
40.01	Sequestration adjustment (see instructions)	92,773	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	6,396,409	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-1,850,531	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1337	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/22/2024 4:36 pm
	Title XVIII	Hospital	Cost

		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	36,434	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/22/2024 4:36 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		2,195,497		6,598,870	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	04/24/2023	151,379	04/24/2023	159,529	3.50
3.51		09/07/2023	38,662	09/07/2023	42,932	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)		-190,041		-202,461	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)		2,005,456		6,396,409	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		413,440		1,850,531	6.02
7.00	Total Medicare program liability (see instructions)		1,592,016		4,545,878	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1337 | Component CCN: 14-Z337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 2/22/2024 4:36 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		240,481		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	04/24/2023	9,743		0	3.50
3.51		09/07/2023	8,735		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)		-18,478		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)		222,003		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		48,971		0	6.02
7.00	Total Medicare program liability (see instructions)		173,032		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1337	Period: From 10/01/2022 To 09/30/2023	Worksheet E-1 Part II Date/Time Prepared: 2/22/2024 4:36 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: 14-1337 | Component CCN: 14-Z337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet E-2 | Date/Time Prepared: 2/22/2024 4:36 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)	155,532	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)	22,231	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	64	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)	177,763	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	177,763	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)	177,763	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,200	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	176,563	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)	176,563	0	19.00
19.01	Sequestration adjustment (see instructions)	3,531	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	222,003	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)	-48,971	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: 14-1337	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part V Date/Time Prepared: 2/22/2024 4:36 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,888,528	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)	1,888,528	4.00
5.00	Primary payer payments	3,224	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,904,189	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)	1,904,189	19.00
20.00	Deductibles (exclude professional component)	303,321	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,600,868	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,600,868	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	36,366	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	23,638	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	34,810	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,624,506	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)	1,624,506	30.00
30.01	Sequestration adjustment (see instructions)	32,490	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2,005,456	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)	-413,440	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	5,143	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G | Date/Time Prepared: 2/22/2024 4:36 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	8,608,465	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	8,066,896	0	0	0	4.00
5.00	Other receivable	171,513	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,176,963	0	0	0	6.00
7.00	Inventory	937,640	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	186,705	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	15,794,256	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	320,233	0	0	0	12.00
13.00	Land improvements	92,482	0	0	0	13.00
14.00	Accumulated depreciation	-38,647	0	0	0	14.00
15.00	Buildings	9,116,569	0	0	0	15.00
16.00	Accumulated depreciation	-1,277,961	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	2,438,260	0	0	0	19.00
20.00	Accumulated depreciation	47,513	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	666,422	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,364,871	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,096,731	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	5,399,717	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,496,448	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	33,655,575	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,200,672	0	0	0	37.00
38.00	Salaries, wages, and fees payable	258,685	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	228,440	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,687,797	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	780,179	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	780,179	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,467,976	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	31,187,599				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)	31,187,599	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	33,655,575	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-1 | Date/Time Prepared: 2/22/2024 4:36 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		19,040,344		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		13,113,164				2.00
3.00	Total (sum of line 1 and line 2)		32,153,508		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)		32,153,508		0		11.00
12.00	EQUITY TRANSFERS	965,909		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)		965,909		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		31,187,599		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	EQUITY TRANSFERS		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: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/22/2024 4:36 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,543,356		1,543,356	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	112,410		112,410	5.00
6.00	Swing bed - NF	42,533		42,533	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)	1,698,299		1,698,299	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	143,085		143,085	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	143,085		143,085	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,841,384		1,841,384	17.00
18.00	Ancillary services	3,535,383	91,410,597	94,945,980	18.00
19.00	Outpatient services	425,966	17,651,655	18,077,621	19.00
20.00	RURAL HEALTH CLINIC	0	8,870,295	8,870,295	20.00
20.01	RURAL HEALTH CLINIC - HENRY	0	328,059	328,059	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER NRCC AND PROFESSIONAL FEES	0	1,318,613	1,318,613	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,802,733	119,579,219	125,381,952	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		43,084,291		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		43,084,291		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1337	Period: From 10/01/2022 To 09/30/2023	Worksheet G-3 Date/Time Prepared: 2/22/2024 4:36 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	125,381,952	1.00
2.00	Less contractual allowances and discounts on patients' accounts	70,610,151	2.00
3.00	Net patient revenues (line 1 minus line 2)	54,771,801	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	43,084,291	4.00
5.00	Net income from service to patients (line 3 minus line 4)	11,687,510	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	4,206	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 OPERATING INCOME	1,316,906	24.00
24.01	INVESTMENT INCOME AND OTHER	104,542	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,425,654	25.00
26.00	Total (line 5 plus line 25)	13,113,164	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)	13,113,164	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 14-1337 | Component CCN: 14-8549 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/22/2024 4:36 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	923,000	247,858	1,170,858	0	1,170,858	1.00
2.00	Physician Assistant	148,061	39,760	187,821	0	187,821	2.00
3.00	Nurse Practitioner	721,670	193,794	915,464	0	915,464	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,187,398	318,858	1,506,256	0	1,506,256	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	6,802	1,827	8,629	0	8,629	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	116,694	31,336	148,030	0	148,030	9.00
10.00	Subtotal (sum of lines 1 through 9)	3,103,625	833,433	3,937,058	0	3,937,058	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	242,599	242,599	0	242,599	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	92,725	92,725	0	92,725	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	335,324	335,324	0	335,324	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,103,625	1,168,757	4,272,382	0	4,272,382	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	5,729	1,538	7,267	0	7,267	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)	5,729	1,538	7,267	0	7,267	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	22,686	22,686	0	22,686	29.00
30.00	Administrative Costs	631,565	1,001,402	1,632,967	57,852	1,690,819	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	631,565	1,024,088	1,655,653	57,852	1,713,505	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,740,919	2,194,383	5,935,302	57,852	5,993,154	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1337 | Component CCN: 14-8549 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/22/2024 4:36 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	1,170,858		1.00
2.00	Physician Assistant	0	187,821		2.00
3.00	Nurse Practitioner	0	915,464		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	1,506,256		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	8,629		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	148,030		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,937,058		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	242,599		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	92,725		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	335,324		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	4,272,382		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	7,267		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	7,267		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	22,686		29.00
30.00	Administrative Costs	-302,127	1,388,692		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-302,127	1,411,378		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-302,127	5,691,027		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1337 | Component CCN: 14-8647 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/22/2024 4:36 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	28,334	7,748	36,082	-7,088	28,994	2.00
3.00	Nurse Practitioner	61,380	16,785	78,165	-15,355	62,810	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	70,287	19,221	89,508	-17,583	71,925	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	3,985	1,090	5,075	-997	4,078	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	163,986	44,844	208,830	-41,023	167,807	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	11,098	11,098	-1,038	10,060	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	1,830	1,830	-171	1,659	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	12,928	12,928	-1,209	11,719	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	163,986	57,772	221,758	-42,232	179,526	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	5	1	6	-1	5	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)	5	1	6	-1	5	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	10,446	10,446	-977	9,469	29.00
30.00	Administrative Costs	35,613	65,568	101,181	-34,403	66,778	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	35,613	76,014	111,627	-35,380	76,247	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	199,604	133,787	333,391	-77,613	255,778	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1337 | Component CCN: 14-8647 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-1 | Date/Time Prepared: 2/22/2024 4:36 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	28,994		2.00
3.00	Nurse Practitioner	0	62,810		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	71,925		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	4,078		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	167,807		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	10,060		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	1,659		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	11,719		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	179,526		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	5		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	5		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	9,469		29.00
30.00	Administrative Costs	0	66,778		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	76,247		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	255,778		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1337 | Component CCN: 14-8549 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/22/2024 4:36 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	2.41	10,126	4,200	10,122		1.00
2.00	Physician Assistant	0.81	3,450	2,100	1,701		2.00
3.00	Nurse Practitioner	4.18	15,625	2,100	8,778		3.00
4.00	Subtotal (sum of lines 1 through 3)	7.40	29,201		20,601	29,201	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	0.09	95			95	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	7.49	29,296			29,296	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)					4,272,382	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					7,267	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					4,279,649	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.998302	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,411,378	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,739,403	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,150,781	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					3,150,781	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					3,145,431	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					7,417,813	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1337 | Component CCN: 14-8647 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-2 | Date/Time Prepared: 2/22/2024 4:36 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.18	94	2,100	378		2.00
3.00	Nurse Practitioner	0.31	776	2,100	651		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.49	870		1,029	1,029	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	0.05	128			128	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.54	998			1,157	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)					179,526	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					5	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					179,531	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999972	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					76,247	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					70,408	15.00
16.00	Total overhead (sum of lines 14 and 15)					146,655	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					146,655	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					146,651	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					326,177	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1337 Component CCN: 14-8549	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/22/2024 4:36 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)			7,417,813	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			192,098	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			7,225,715	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			29,296	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)			29,296	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			246.65	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	258.63	268.45		8.00
9.00	Rate for Program covered visits (see instructions)	246.65	246.65		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	1,719	5,516		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	423,991	1,360,521		11.00
12.00	Program covered visits for mental health services (from contractor records)	1	17		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	247	4,193		13.00
14.00	Limit adjustment for mental health services (see instructions)	247	4,193		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	1,788,952		16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,876,567		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		49,379		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		47,073		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.)		1,226,510		16.04
16.05	Total program cost (see instructions)	0	1,273,583		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		208,741		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		322,226		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,273,583		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		73,159		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,346,742		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)		1,346,742		26.00
26.01	Sequestration adjustment (see instructions)		26,935		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		1,342,282		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)		-22,475		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: 14-1337 Component CCN: 14-8647	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3 Date/Time Prepared: 2/22/2024 4:36 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)			326,177	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			3,879	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			322,298	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,157	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)			1,157	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			278.56	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	113.00	126.00		8.00
9.00	Rate for Program covered visits (see instructions)	113.00	126.00		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	150		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	18,900		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	8		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	1,008		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	1,008		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	19,908		16.00
16.01	Total program charges (see instructions)(from contractor's records)		42,829		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		174		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		81		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.)		14,181		16.04
16.05	Total program cost (see instructions)	0	14,262		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		2,101		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		8,111		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		14,262		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		231		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		14,493		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)		14,493		26.00
26.01	Sequestration adjustment (see instructions)		290		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		6,248		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		7,955		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: 14-1337 | Component CCN: 14-8549 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4 | Date/Time Prepared: 2/22/2024 4:36 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)	3,937,058	3,937,058	3,937,058	3,937,058	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001620	0.005601	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	6,378	22,051	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	58,341	23,871	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	64,719	45,922	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	4,272,382	4,272,382	4,272,382	4,272,382	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	3,145,431	3,145,431	3,145,431	3,145,431	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.015148	0.010749	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	47,647	33,810	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	112,366	79,732	0	0	10.00
11.00	Total number of injections/infusions (from your records)	280	968	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	401.31	82.37	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	108	362	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	43,341	29,818	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)		192,098	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)		73,159	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1337 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-4

Component CCN: 14-8647 | Date/Time Prepared: 2/22/2024 4:36 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)	167,807	167,807	167,807	167,807	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000424	0.003075	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	71	516	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	833	715	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	904	1,231	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	179,526	179,526	179,526	179,526	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	146,651	146,651	146,651	146,651	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.005035	0.006857	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	738	1,006	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1,642	2,237	0	0	10.00
11.00	Total number of injections/infusions (from your records)	4	29	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	410.50	77.14	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	3	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	231	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)		3,879	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)		231	16.00

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

Provider CCN: 14-1337 | Component CCN: 14-8549 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-5 | Date/Time Prepared: 2/22/2024 4:36 pm

RHC I | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,349,820	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		04/24/2023	7,538	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)		-7,538	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,342,282	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		22,475	6.02
7.00	Total Medicare program liability (see instructions)		1,319,807	7.00

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

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

Provider CCN: 14-1337 | Component CCN: 14-8647 | Period: From 10/01/2022 To 09/30/2023 | Worksheet M-5 | Date/Time Prepared: 2/22/2024 4:36 pm

RHC II | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		6,248	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		6,248	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		7,955	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		14,203	7.00

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