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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: 14-0001	Period: From 07/01/2022 To 06/30/2023	Worksheet S Parts I-III Date/Time Prepared: 11/30/2023 12:56 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/30/2023 Time: 12:56 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 GRAHAM HOSPITAL ASSOCIATION (14-0001) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 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	Julie Reeder		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Julie Reeder			2
3	Signatory Title	CFO			3
4	Date	11/30/2023 12:56:38 PM			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	-748,420	-163,508	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	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	67,317	9		0	7.00
8.00	NURSING FACILITY	0				0	8.00
10.00	RURAL HEALTH CLINIC I	0		163,818		0	10.00
10.01	ELMWOOD RHC II	0		30,319		0	10.01
10.02	WILLIAMSFIELD RHC III	0		2,154		0	10.02
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	TOTAL	0	-681,103	32,792	0	0	200.00

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/30/2023 12:56 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 210 WEST WALNUT	PO Box:			1.00
2.00	City: CANTON	State: IL	Zip Code: 61520-	County: FULTON	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	GRAHAM HOSPITAL ASSOCIATION	140001	37900	1	07/19/1966	N	P	N	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									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	GRAHAM HOSPITAL ASSOCIATION ECF	145572	99914		07/02/1987	N	P	N	9.00
10.00	Hospital-Based NF	GRAHAM HOSPITAL ASSOCIATION ECF	145572	99914		07/02/1987	N		O	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	GRAHAM MEDICAL GROUP - LEWISTOWN	143493	99914		01/01/2008	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	GRAHAM MEDICAL GROUP - ELMWOOD	148603	99914		10/23/2019	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	GRAHAM MEDICAL GROUP - WILLIAMSFIELD	148636	99914		02/17/2023	N	O	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2022	06/30/2023	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	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)	Y	Y		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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/30/2023 12:56 pm

		1.00	2.00	3.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,293	0	0	0	119	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1		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.	07/01/2022	06/30/2023	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)	Y	Y	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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/30/2023 12:56 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		20.00	1	60.01

		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)				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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0001	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/30/2023 12:56 pm

						1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

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

		1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)		
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?	N	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.		0	88.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I | Date/Time Prepared: 11/30/2023 12:56 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		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
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		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)			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.					109.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part I Date/Time Prepared: 11/30/2023 12:56 pm

				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N		111.00
		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	1,527,696	118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		Y	5.00	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.				123.00
	Certified Transplant Center Information				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0001	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/30/2023 12:56 pm

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

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

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

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

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0001	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Prepared: 11/30/2023 12:56 pm

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

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HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/30/2023 12:56 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		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?	Y	Y	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	11/06/2023	Y	11/06/2023	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

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HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/30/2023 12:56 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KELLY	BETH	41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	414.259.6738	KBETH@WIPFLI.COM	43.00

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HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-2 Part II | Date/Time Prepared: 11/30/2023 12:56 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.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/30/2023 12:56 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	33	12,045	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		33	12,045	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	10	3,650	0.00	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	43.00				0	13.00
14.00	Total (see instructions)		43	15,695	0.00	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	44.00	20	7,300		0	19.00
20.00	NURSING FACILITY	45.00	18	6,570		0	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	RHC (CONSOLIDATED)	88.00				0	26.00
26.01	ELMWOOD RHC	88.01				0	26.01
26.02	WILLIAMSFIELD RHC	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		81				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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/30/2023 12:56 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)	2,427	925	5,164			1.00
2.00	HMO and other (see instructions)	1,739	119				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,427	925	5,164			7.00
8.00	INTENSIVE CARE UNIT	477	136	1,144			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		232	356			13.00
14.00	Total (see instructions)	2,904	1,293	6,664	0.00	472.86	14.00
15.00	CAH visits	0	0	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	1,308	19	2,262	0.00	12.75	19.00
20.00	NURSING FACILITY		3,427	5,384	0.00	13.24	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	RHC (CONSOLIDATED)	16,166	30,005	100,911	0.00	113.22	26.00
26.01	ELMWOOD RHC	770	1,264	5,659	0.00	7.21	26.01
26.02	WILLIAMSFIELD RHC	0	0	1,894	0.00	2.13	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	621.41	27.00
28.00	Observation Bed Days		0	1,590			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	40	96			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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part I | Date/Time Prepared: 11/30/2023 12:56 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	663	323	1,633	1.00
2.00	HMO and other (see instructions)			375	0		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	663	323	1,633	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0.00					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	RHC (CONSOLIDATED)	0.00					26.00
26.01	ELMWOOD RHC	0.00					26.01
26.02	WILLIAMSFIELD RHC	0.00					26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

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HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part II | Date/Time Prepared: 11/30/2023 12:56 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	49,902,322	0	49,902,322	1,292,553.60	38.61	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		1,756,721	0	1,756,721	12,084.80	145.37	3.00
4.00	Physician-Part A - Administrative		463,047	0	463,047	2,008.12	230.59	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		9,862,192	0	9,862,192	74,603.08	132.20	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		3,877,796	0	3,877,796	65,062.40	59.60	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	870,727	0	870,727	26,520.00	32.83	9.00
10.00	Excluded area salaries (see instructions)		1,968,923	121,956	2,090,879	58,655.97	35.65	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,552,662	0	1,552,662	14,461.65	107.36	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		57,000	0	57,000	500.00	114.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,096,280	0	5,096,280			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		647,715	0	647,715			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		577,771	0	577,771			21.00
22.00	Physician Part A - Administrative		152,291	0	152,291			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		1,724,606	0	1,724,606			23.00
24.00	Wage-related costs (RHC/FQHC)		4,048,614	0	4,048,614			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

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HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part II | Date/Time Prepared: 11/30/2023 12:56 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	253,801	0	253,801	9,401.60	27.00	26.00
27.00	Administrative & General	5.00	9,582,701	0	9,582,701	276,452.80	34.66	27.00
28.00	Administrative & General under contract (see inst.)		925,283	0	925,283	10,920.00	84.73	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,081,721	-463	1,081,258	48,235.20	22.42	30.00
31.00	Laundry & Linen Service	8.00	4,385	49,732	54,117	3,286.00	16.47	31.00
32.00	Housekeeping	9.00	1,193,257	-49,732	1,143,525	60,507.00	18.90	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	939,061	-526,062	412,999	19,356.83	21.34	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	526,062	526,062	24,655.97	21.34	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	681,707	0	681,707	18,075.20	37.72	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	893,701	0	893,701	25,334.40	35.28	40.00
41.00	Medical Records & Medical Records Library	16.00	662,814	0	662,814	29,265.60	22.65	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

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HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part III | Date/Time Prepared: 11/30/2023 12:56 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		35,330,896	0	35,330,896	1,151,723.32	30.68	1.00
2.00	Excluded area salaries (see instructions)		2,839,650	121,956	2,961,606	85,175.97	34.77	2.00
3.00	Subtotal salaries (line 1 minus line 2)		32,491,246	-121,956	32,369,290	1,066,547.35	30.35	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,609,662	0	1,609,662	14,961.65	107.59	4.00
5.00	Subtotal wage-related costs (see inst.)		5,248,571	0	5,248,571	0.00	16.21	5.00
6.00	Total (sum of lines 3 thru 5)		39,349,479	-121,956	39,227,523	1,081,509.00	36.27	6.00
7.00	Total overhead cost (see instructions)		16,218,431	-463	16,217,968	525,490.60	30.86	7.00

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HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part IV | Date/Time Prepared: 11/30/2023 12:56 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,034,939	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	5,044	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	7,000	6.00
7.00	Employee Managed Care Program Administration Fees	-13,631	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	6,736,405	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	12,588	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	232,968	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	741,805	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	3,274,388	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	-5,369	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	164,517	21.00
22.00	Day Care Cost and Allowances	56,624	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,247,278	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS		25.00

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HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-3 Part V Date/Time Prepared: 11/30/2023 12:56 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,552,662	12,247,278	1.00
2.00	Hospital	1,552,662	12,247,278	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY	0	0	8.00
9.00	NURSING FACILITY	0	0	9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

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HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0001 | Component CCN: 14-3493 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 11/30/2023 12:56 pm

RHC I | Cost

					1.00		
	Clinic Address and Identification						
1.00	Street				180 S MAIN STREET		1.00
		City			State	ZIP Code	
		1.00			2.00	3.00	
2.00	City, State, ZIP Code, County	CANTON			IL	61520	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0	3.00
				Grant Award		Date	
				1.00		2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)						4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)						5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)						6.00
7.00	Appalachian Regional Commission						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N	0	10.00
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC	08:30	15:00	07:30	17:30	07:30	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				Y	3	13.00
				Provider name		CCN	
				1.00		2.00	
14.00	RHC/FQHC name, CCN			FARMINGTON CLINIC		143494	14.00
14.01				CANTON CLINIC		143492	14.01
14.02				LEWISTOWN CLINIC		143493	14.02
		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		FULTON				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:30	07:30	17:30	07:30	17:30	11.00

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HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0001
Component CCN: 14-3493

Period:
From 07/01/2022
To 06/30/2023

Worksheet S-8

Date/Time Prepared:
11/30/2023 12:56 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	07:30	17:30	08:30	17:00		11.00

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HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0001 | Component CCN: 14-8603 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 11/30/2023 12:56 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1024 N MAGNOLIA STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ELMWOOD		IL	61529	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	17:30	08:00	11.00

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

		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		PEORIA				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:30	08:00	17:30	08:00	17:30	11.00

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HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0001
Component CCN: 14-8603

Period:
From 07/01/2022
To 06/30/2023

Worksheet S-8

Date/Time Prepared:
11/30/2023 12:56 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	17:30				11.00

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HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0001 | Component CCN: 14-8636 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-8 | Date/Time Prepared: 11/30/2023 12:56 pm

RHC III | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street				120 E GALE ST.	1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WILLIAMSFIELD		IL	64189	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
					1.00	2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N	0 10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			08:00	16:30	11.00
					1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?					12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0 13.00
				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		KNOX			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	16:30		11.00

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HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0001
Component CCN: 14-8636

Period:
From 07/01/2022
To 06/30/2023

Worksheet S-8

Date/Time Prepared:
11/30/2023 12:56 pm

RHC III | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:30				11.00

STATE COPY

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet S-10 | Date/Time Prepared: 11/30/2023 12:56 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.355656	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	8,319,458	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	63,312,071	6.00
7.00	Medicaid cost (line 1 times line 6)	22,517,318	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	14,197,860	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 (line 11 minus line 9; if < zero then enter zero)	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 (line 15 minus line 13; if < zero then enter zero)	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)	14,197,860	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,028,469	804,549	2,833,018	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	721,437	804,549	1,525,986	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 (line 21 minus line 22)	721,437	804,549	1,525,986	23.00

		1.00	
24.00	Does the amount on line 20 column 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
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,510,160	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	302,372	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	465,187	27.01
28.00	Non-Medicare bad debt expense (see instructions)	4,044,973	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,601,434	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,127,420	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	17,325,280	31.00

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RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/30/2023 12:56 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		7,384,159	7,384,159	-1,765,619	5,618,540	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,821,321	1,821,321	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	253,801	13,031,042	13,284,843	-73,107	13,211,736	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,582,701	8,105,955	17,688,656	-146,919	17,541,737	5.00
7.00	00700	OPERATION OF PLANT	1,081,721	2,008,407	3,090,128	-463	3,089,665	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,385	307,254	311,639	49,732	361,371	8.00
9.00	00900	HOUSEKEEPING	1,193,257	240,712	1,433,969	-49,732	1,384,237	9.00
10.00	01000	DIETARY	939,061	768,425	1,707,486	-956,534	750,952	10.00
11.00	01100	CAFETERIA	0	0	0	956,534	956,534	11.00
13.00	01300	NURSING ADMINISTRATION	681,707	78,295	760,002	0	760,002	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	893,701	98,222	991,923	0	991,923	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	662,814	311,695	974,509	0	974,509	16.00
20.00	02000	NURSING PROGRAM	1,010,979	213,972	1,224,951	0	1,224,951	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,268,089	952,180	4,220,269	1,313,785	5,534,054	30.00
31.00	03100	INTENSIVE CARE UNIT	964,284	134,035	1,098,319	-3,905	1,094,414	31.00
43.00	04300	NURSERY	0	0	0	8,873	8,873	43.00
44.00	04400	SKILLED NURSING FACILITY	870,727	68,384	939,111	0	939,111	44.00
45.00	04500	NURSING FACILITY	867,465	36,051	903,516	0	903,516	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,922,906	4,985,099	6,908,005	-3,275,438	3,632,567	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0	0	17,090	17,090	52.01
53.00	05300	ANESTHESIOLOGY	1,756,721	38,605	1,795,326	0	1,795,326	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,234,807	1,298,223	2,533,030	-2,453	2,530,577	54.00
57.00	05700	CT SCAN	0	346,495	346,495	0	346,495	57.00
58.00	05800	MRI	18,620	313,840	332,460	0	332,460	58.00
60.00	06000	LABORATORY	1,904,962	3,195,993	5,100,955	0	5,100,955	60.00
65.00	06500	RESPIRATORY THERAPY	654,771	127,984	782,755	0	782,755	65.00
66.00	06600	PHYSICAL THERAPY	1,751,446	67,797	1,819,243	0	1,819,243	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	987,031	987,031	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,325,354	2,325,354	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,368,856	2,368,856	0	2,368,856	73.00
76.97	07697	CARDIAC REHABILITATION	220,588	123,008	343,596	5,893	349,489	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,644,132	10,980,398	24,624,530	-2,954,663	21,669,867	88.00
88.01	08801	ELMWOOD RHC	0	0	0	1,231,183	1,231,183	88.01
88.02	08802	WILLIAMSFIELD RHC	0	0	0	134,067	134,067	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	587,546	570,418	1,157,964	61,705	1,219,669	90.01
91.00	09100	EMERGENCY	3,233,034	906,688	4,139,722	63,688	4,203,410	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	607,618	948,788	1,556,406	15,316	1,571,722	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,811,843	60,010,980	109,822,823	-237,261	109,585,562	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	1,071	1,071	463	1,534	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	11,765	11,765	5,683	17,448	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	90,479	21,603	112,082	0	112,082	194.11
194.12	07962	AVON CLINIC	0	0	0	0	0	194.12
194.13	07963	WILLIAMSFIELD CLINIC	0	0	0	231,115	231,115	194.13
200.00		TOTAL (SUM OF LINES 118 through 199)	49,902,322	60,045,419	109,947,741	0	109,947,741	200.00

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RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A | Date/Time Prepared: 11/30/2023 12:56 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	-765,496	4,853,044		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-14,344	1,806,977		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-840,438	12,371,298		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,489,006	14,052,731		5.00
7.00	00700	OPERATION OF PLANT	-1,859	3,087,806		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	361,371		8.00
9.00	00900	HOUSEKEEPING	0	1,384,237		9.00
10.00	01000	DIETARY	-365,232	385,720		10.00
11.00	01100	CAFETERIA	-293,890	662,644		11.00
13.00	01300	NURSING ADMINISTRATION	-1,613	758,389		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	-100,563	891,360		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,622	968,887		16.00
20.00	02000	NURSING PROGRAM	-253,708	971,243		20.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	5,534,054		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,094,414		31.00
43.00	04300	NURSERY	0	8,873		43.00
44.00	04400	SKILLED NURSING FACILITY	-1,040	938,071		44.00
45.00	04500	NURSING FACILITY	0	903,516		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,632,567		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	17,090		52.01
53.00	05300	ANESTHESIOLOGY	-1,756,721	38,605		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,530,577		54.00
57.00	05700	CT SCAN	0	346,495		57.00
58.00	05800	MRI	0	332,460		58.00
60.00	06000	LABORATORY	-58,353	5,042,602		60.00
65.00	06500	RESPIRATORY THERAPY	0	782,755		65.00
66.00	06600	PHYSICAL THERAPY	0	1,819,243		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	987,031		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,325,354		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-7	2,368,849		73.00
76.97	07697	CARDIAC REHABILITATION	-47,147	302,342		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-476,563	21,193,304		88.00
88.01	08801	ELMWOOD RHC	0	1,231,183		88.01
88.02	08802	WILLIAMSFIELD RHC	0	134,067		88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	-222,052	997,617		90.01
91.00	09100	EMERGENCY	-2,460,715	1,742,695		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	-18,684	1,553,038		96.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,173,053	98,412,509		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	1,534		192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0		192.01
193.00	19300	NONPAID WORKERS	0	0		193.00
193.02	19302	FOUNDATION	0	0		193.02
194.00	07950	PHYSICIANS CLINIC	0	0		194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0		194.01
194.02	07952	FRESENIUS	0	0		194.02
194.03	07953	RUCHFORD POB	0	17,448		194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0		194.04
194.05	07955	FARMINGTON POB	0	0		194.05
194.06	07956	LEWISTON POB	0	0		194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0		194.07
194.08	07958	KELLEY HOME	0	0		194.08
194.09	07959	EMPLOYEE PURCHASE	0	0		194.09
194.10	07960	RETAIL PHARMACY	0	0		194.10
194.11	07961	WELLNESS CENTER	0	112,082		194.11
194.12	07962	AVON CLINIC	0	0		194.12
194.13	07963	WILLIAMSFIELD CLINIC	0	231,115		194.13
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,173,053	98,774,688		200.00

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RECLASSIFICATIONS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/30/2023 12:56 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	526,062	430,472		1.00
	TOTALS		526,062	430,472		
	B - MAINTENANCE LABOR RECLASS					
1.00	PHYSICIANS PRIVATE OFFICES	192.00	463	0		1.00
	TOTALS		463	0		
	C - OFFSITE CAPITAL RECLASS					
1.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	15,316		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	55,220		2.00
3.00	RUCHFORD POB	194.03	0	4,121		3.00
	TOTALS		0	74,657		
	D - PROPERTY INSURANCE RECLASS					
1.00	OTHER CAP REL COSTS	3.00	0	133,313		1.00
2.00	RUCHFORD POB	194.03	0	1,562		2.00
	TOTALS		0	134,875		
	E - DEPRECIATION RECLASS					
1.00	CARDIAC REHABILITATION	76.97	0	2,954		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,790,390		2.00
	TOTALS		0	1,793,344		
	F - RHC EXPENSE RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	1,349,661	0		1.00
2.00	ELMWOOD RHC	88.01	647,209	583,974		2.00
3.00	WILLIAMSFIELD RHC	88.02	70,476	63,591		3.00
4.00	WOUND CLINIC	90.01	63,857	0		4.00
5.00	WILLIAMSFIELD CLINIC	194.13	121,493	109,622		5.00
	TOTALS		2,252,696	757,187		
	G - EMPLOYEE BENEFIT AUDIT RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	12,044		1.00
	TOTALS		0	12,044		
	H - IMPLANT RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,325,354		1.00
	TOTALS		0	2,325,354		
	I - MED SUP CHARGE TO PATIENTS RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	987,031		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
	TOTALS		0	987,031		
	J - RECLASS PHYSICIAN BENEFITS					
1.00	CARDIAC REHABILITATION	76.97	0	2,939		1.00
2.00	WOUND CLINIC	90.01	0	10,190		2.00
3.00	EMERGENCY	91.00	0	72,022		3.00
	TOTALS		0	85,151		
	K - RECLASS OB SALARIES					
1.00	NURSERY	43.00	8,873	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.01	17,090	0		2.00
	TOTALS		25,963	0		
	L - LAUNDRY & LINEN SALARIES					
1.00	LAUNDRY & LINEN SERVICE	8.00	49,732	0		1.00
	TOTALS		49,732	0		
500.00	Grand Total: Increases		2,854,916	6,600,115		500.00

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RECLASSIFICATIONS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-6 | Date/Time Prepared: 11/30/2023 12:56 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	526,062	430,472	0		1.00
	TOTALS		526,062	430,472			
	B - MAINTENANCE LABOR RECLASS						
1.00	OPERATION OF PLANT	7.00	463	0	0		1.00
	TOTALS		463	0			
	C - OFFSITE CAPITAL RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	74,657	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	74,657			
	D - PROPERTY INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	134,875	12		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	134,875			
	E - DEPRECIATION RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,793,344	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	1,793,344			
	F - RHC EXPENSE RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	2,252,696	757,187	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
	TOTALS		2,252,696	757,187			
	G - EMPLOYEE BENEFIT AUDIT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,044	0		1.00
	TOTALS		0	12,044			
	H - IMPLANT RECLASS						
1.00	OPERATING ROOM	50.00	0	2,325,354	0		1.00
	TOTALS		0	2,325,354			
	I - MED SUP CHARGE TO PATIENTS RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	9,913	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	3,905	0		2.00
3.00	OPERATING ROOM	50.00	0	950,084	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,453	0		4.00
5.00	WOUND CLINIC	90.01	0	12,342	0		5.00
6.00	EMERGENCY	91.00	0	8,334	0		6.00
	TOTALS		0	987,031			
	J - RECLASS PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	85,151	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	85,151			
	K - RECLASS OB SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	25,963	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		25,963	0			
	L - LAUNDRY & LINEN SALARIES						
1.00	HOUSEKEEPING	9.00	49,732	0	0		1.00
	TOTALS		49,732	0			
500.00	Grand Total: Decreases		2,854,916	6,600,115			500.00

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RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part I | Date/Time Prepared: 11/30/2023 12:56 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,392,453	5,885,501	0	5,885,501	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	101,009,218	1,483,708	0	1,483,708	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	13,155,219	2,738,257	0	2,738,257	171,894	5.00
6.00	Movable Equipment	37,307,806	3,490,300	0	3,490,300	1,373,811	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	157,864,696	13,597,766	0	13,597,766	1,545,705	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	157,864,696	13,597,766	0	13,597,766	1,545,705	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	12,277,954	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	102,492,926	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	15,721,582	0	5.00
6.00	Movable Equipment	39,424,295	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	169,916,757	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	169,916,757	0	10.00

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RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part II | Date/Time Prepared: 11/30/2023 12:56 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	7,384,159	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	7,384,159	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	7,384,159	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	7,384,159	3.00

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RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-7 Part III | Date/Time Prepared: 11/30/2023 12:56 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	130,492,461	0	130,492,461	0.767979	102,382	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	39,424,296	0	39,424,296	0.232021	30,931	2.00
3.00	Total (sum of lines 1-2)	169,916,757	0	169,916,757	1.000000	133,313	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	102,382	5,516,158	-424,080	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	30,931	1,776,046	0	2.00
3.00	Total (sum of lines 1-2)	0	0	133,313	7,292,204	-424,080	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-341,416	102,382	0	0	4,853,044	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	30,931	0	0	1,806,977	2.00
3.00	Total (sum of lines 1-2)	-341,416	133,313	0	0	6,660,021	3.00

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ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/30/2023 12:56 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-239,557	CAP REL COSTS-BLDG & FIXT	1.00	11	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)	B	-38,382	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-212	ADMINISTRATIVE & GENERAL	5.00	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)	A	-3,967	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,593,421			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-293,890	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,622	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

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ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8 | Date/Time Prepared: 11/30/2023 12:56 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	DIETARY VENDOR REBATES/REFUNDS	B	-6,246	DIETARY	10.00	0	33.00
33.01	MEDICAL STAFF DUES	B	-9,520	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	ADMIN OTHER INCOME	B	-223,600	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PLANT OPS OTHER INCOME	B	-1,859	OPERATION OF PLANT	7.00	0	33.03
33.04	HOUSEKEEPING OTHER INCOME	B	0	HOUSEKEEPING	9.00	0	33.04
33.05	DIETARY CONSULTANT AND EMP PURCHASE	B	-358,986	DIETARY	10.00	0	33.05
33.06	NURSING & ADMIN CPR CLASS FEES	B	-1,613	NURSING ADMINISTRATION	13.00	0	33.06
33.07	PHARMACY OTHER INCOME	B	0	PHARMACY	15.00	0	33.07
33.08	SALE OF DRUGS TO OTEHR THAN PATIENTS	B	-100,563	PHARMACY	15.00	0	33.08
33.09	REFUNDS & REBATES - PHARMACY	B	0	PHARMACY	15.00	0	33.09
33.10	CARDIAC REHAB OTHER INCOME	B	-27,814	CARDIAC REHABILITATION	76.97	0	33.10
33.11	RHC OTHER INCOME	B	-476,563	RURAL HEALTH CLINIC	88.00	0	33.11
33.12	WOUND CLINIC OTHER INCOME	B	-167,000	WOUND CLINIC	90.01	0	33.12
33.13	DME NON-PATIENT SALES	B	-9,018	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.13
33.14	DME OTHER INCOME	B	-5,891	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.14
33.15	LAB OTHER INCOME	B	0	LABORATORY	60.00	0	33.15
33.16	NURSING SCHOOL REVENUE	B	-253,708	NURSING PROGRAM	20.00	0	33.16
33.17	DONATIONS	B	-13,525	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	DONATIONS	B	-32	CARDIAC REHABILITATION	76.97	0	33.18
33.19	DONATIONS	B	-7	DRUGS CHARGED TO PATIENTS	73.00	0	33.19
33.20	CRNA CONTRACTED EXPENSES	A	0	ANESTHESIOLOGY	53.00	0	33.20
33.21	CRNA SALARIES	A	-1,756,721	ANESTHESIOLOGY	53.00	0	33.21
33.22	CRNA BENEFITS	A	-352,902	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.22
33.23	REFUNDS & REBATES - LAB	A	0	LABORATORY	60.00	0	33.23
33.24	ILLINOIS MA PROVIDER TAX	A	-2,984,628	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	PHONE SALARIES	A	-2,488	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	PHONE BENEFITS	A	-500	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.26
33.27	PHONE OTHER EXP	A	-985	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28	PHONE DEPR	A	-27	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.28
33.29	IHA & AHA DUES LOBBYING PORTION	A	-25,925	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	IL HEALTHCARE ASSOCIATION LOBBYING	A	-1,040	SKILLED NURSING FACILITY	44.00	0	33.30
33.31	MARKETING SALARIES	A	-90,739	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	MARKETING BENEFITS	A	-18,228	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.32
33.33	MARKETING OTHER EXPENSE	A	-66,084	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	MARKETING DEPR	A	-10,350	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.34
33.35	PHYSICIAN RECRUITMENT	A	-32,918	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	LOAN FORGIVENESS EXPENSE	A	-468,808	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.36
33.37	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.37
33.38	SWAP INTEREST RATE EXPENSE	A	-101,859	CAP REL COSTS-BLDG & FIXT	1.00	11	33.38
33.39	DME EMPLOYEE & GUEST REVENUE	B	-3,775	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.39
33.40	EMERGENCY ROOM OTHER REVENUE	B	0	EMERGENCY	91.00	0	33.40
33.41	RENTAL REVENUE	B	-424,080	CAP REL COSTS-BLDG & FIXT	1.00	10	33.41
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,173,053				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.

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PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet A-8-2 | Date/Time Prepared: 11/30/2023 12:56 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	2,610,443	2,069,037	541,406	171,400	1,817	1.00
2.00	90.01	WOUND CLINIC	66,918	30,918	36,000	171,400	144	2.00
3.00	76.97	CARDIAC REHABILITATION	19,301	19,301	0	0	0	3.00
4.00	60.00	LABORATORY	57,000	0	57,000	171,400	500	4.00
5.00	60.00	LABORATORY	42,555	42,555	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,796,217	2,161,811	634,406		2,461	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	149,728	7,486	0	0	0	1.00
2.00	90.01	WOUND CLINIC	11,866	593	0	0	0	2.00
3.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	41,202	2,060	0	0	0	4.00
5.00	60.00	LABORATORY	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			202,796	10,139	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	149,728	391,678	2,460,715		1.00
2.00	90.01	WOUND CLINIC	0	11,866	24,134	55,052		2.00
3.00	76.97	CARDIAC REHABILITATION	0	0	0	19,301		3.00
4.00	60.00	LABORATORY	0	41,202	15,798	15,798		4.00
5.00	60.00	LABORATORY	0	0	0	42,555		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	202,796	431,610	2,593,421		200.00

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COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/30/2023 12:56 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,853,044	4,853,044				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,806,977		1,806,977			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,371,298	19,371	7,213	12,397,882		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,052,731	463,375	172,532	2,549,195	17,237,833	5.00
7.00	00700	OPERATION OF PLANT	3,087,806	438,113	163,126	290,463	3,979,508	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	361,371	95,277	35,475	1,178	493,301	8.00
9.00	00900	HOUSEKEEPING	1,384,237	77,031	28,681	320,549	1,810,498	9.00
10.00	01000	DIETARY	385,720	69,346	25,820	110,946	591,832	10.00
11.00	01100	CAFETERIA	662,644	88,343	32,893	141,318	925,198	11.00
13.00	01300	NURSING ADMINISTRATION	758,389	37,029	13,787	183,130	992,335	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	51,581	19,206	0	70,787	14.00
15.00	01500	PHARMACY	891,360	49,975	18,608	240,078	1,200,021	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	968,887	76,040	28,313	178,054	1,251,294	16.00
20.00	02000	NURSING PROGRAM	971,243	438,073	163,111	271,583	1,844,010	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,534,054	339,288	126,330	1,233,510	7,233,182	30.00
31.00	03100	INTENSIVE CARE UNIT	1,094,414	33,816	12,591	259,039	1,399,860	31.00
43.00	04300	NURSERY	8,873	11,928	4,441	2,384	27,626	43.00
44.00	04400	SKILLED NURSING FACILITY	938,071	80,471	29,963	233,907	1,282,412	44.00
45.00	04500	NURSING FACILITY	903,516	70,859	26,384	233,031	1,233,790	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,632,567	269,232	100,246	516,558	4,518,603	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	17,090	6,305	2,348	4,591	30,334	52.01
53.00	05300	ANESTHESIOLOGY	38,605	4,217	1,570	0	44,392	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,530,577	94,715	35,266	331,711	2,992,269	54.00
57.00	05700	CT SCAN	346,495	78,517	29,235	0	454,247	57.00
58.00	05800	MRI	332,460	22,357	8,324	5,002	368,143	58.00
60.00	06000	LABORATORY	5,042,602	179,015	66,654	511,738	5,800,009	60.00
65.00	06500	RESPIRATORY THERAPY	782,755	26,507	9,870	175,894	995,026	65.00
66.00	06600	PHYSICAL THERAPY	1,819,243	102,560	38,187	470,498	2,430,488	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	987,031	0	0	0	987,031	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,325,354	0	0	0	2,325,354	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,368,849	37,096	13,812	0	2,419,757	73.00
76.97	07697	CARDIAC REHABILITATION	302,342	114,997	42,818	54,540	514,697	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	21,193,304	790,962	294,508	3,060,147	25,338,921	88.00
88.01	08801	ELMWOOD RHC	1,231,183	45,303	16,868	173,862	1,467,216	88.01
88.02	08802	WILLIAMSFIELD RHC	134,067	9,358	3,484	18,932	165,841	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	997,617	56,387	20,995	168,303	1,243,302	90.01
91.00	09100	EMERGENCY	1,742,695	158,412	58,983	437,447	2,397,537	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,553,038	2,048	763	163,227	1,719,076	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	98,412,509	4,437,904	1,652,405	12,340,815	97,785,730	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	7,296	2,717	0	10,013	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,534	47,538	17,700	124	66,896	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	137,314	51,127	0	188,441	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	37,203	13,852	0	51,055	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	80,324	29,908	0	110,232	194.02
194.03	07953	RUCHFORD POB	17,448	0	0	0	17,448	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	89,333	33,262	0	122,595	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	112,082	0	0	24,306	136,388	194.11
194.12	07962	AVON CLINIC	0	0	0	0	0	194.12

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COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/30/2023 12:56 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
194.13	07963	WILLIAMSFIELD CLINIC	231,115	16,132	6,006	32,637	285,890	194.13
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)	98,774,688	4,853,044	1,806,977	12,397,882	98,774,688	202.00

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COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/30/2023 12:56 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,237,833					5.00
7.00	00700	OPERATION OF PLANT	841,316	4,820,824				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	104,290	116,809	714,400			8.00
9.00	00900	HOUSEKEEPING	382,761	94,439	0	2,287,698		9.00
10.00	01000	DIETARY	125,120	85,018	0	65,097	867,067	10.00
11.00	01100	CAFETERIA	195,598	108,307	0	82,930	0	11.00
13.00	01300	NURSING ADMINISTRATION	209,792	45,398	0	34,761	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,965	63,238	0	48,421	0	14.00
15.00	01500	PHARMACY	253,699	61,269	0	46,913	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	264,539	93,224	0	71,381	0	16.00
20.00	02000	NURSING PROGRAM	389,846	537,073	0	411,232	0	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,529,181	415,964	256,085	318,500	310,810	30.00
31.00	03100	INTENSIVE CARE UNIT	295,947	41,459	56,731	31,744	68,855	31.00
43.00	04300	NURSERY	5,840	14,624	17,654	11,197	21,427	43.00
44.00	04400	SKILLED NURSING FACILITY	271,117	98,657	112,174	75,541	136,145	44.00
45.00	04500	NURSING FACILITY	260,838	86,872	266,995	66,518	324,052	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	955,287	330,076	0	252,736	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	6,413	7,730	4,761	5,919	5,778	52.01
53.00	05300	ANESTHESIOLOGY	9,385	5,170	0	3,959	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	632,602	116,120	0	88,912	0	54.00
57.00	05700	CT SCAN	96,033	96,261	0	73,706	0	57.00
58.00	05800	MRI	77,830	27,409	0	20,987	0	58.00
60.00	06000	LABORATORY	1,226,192	219,471	0	168,047	0	60.00
65.00	06500	RESPIRATORY THERAPY	210,360	32,497	0	24,883	0	65.00
66.00	06600	PHYSICAL THERAPY	513,834	125,738	0	96,276	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	208,670	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	491,608	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	511,566	45,480	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	108,813	140,985	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,356,914	969,712	0	0	0	88.00
88.01	08801	ELMWOOD RHC	310,187	55,541	0	0	0	88.01
88.02	08802	WILLIAMSFIELD RHC	35,061	11,472	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	262,849	69,130	0	52,933	0	90.01
91.00	09100	EMERGENCY	506,868	194,212	0	148,706	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	363,433	2,511	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,028,754	4,311,866	714,400	2,201,299	867,067	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	2,117	8,945	0	6,849	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	14,143	58,282	0	44,626	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	39,839	168,345	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	10,794	45,611	0	34,924	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	23,304	98,476	0	0	0	194.02
194.03	07953	RUCHFORD POB	3,689	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	25,918	109,522	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	28,834	0	0	0	0	194.11
194.12	07962	AVON CLINIC	0	0	0	0	0	194.12
194.13	07963	WILLIAMSFIELD CLINIC	60,441	19,777	0	0	0	194.13
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)	17,237,833	4,820,824	714,400	2,287,698	867,067	202.00

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COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/30/2023 12:56 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,312,033					11.00
13.00	01300	NURSING ADMINISTRATION	28,604	1,310,890				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	197,411			14.00
15.00	01500	PHARMACY	37,500	0	0	1,599,402		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,812	0	0	0	1,708,250	16.00
20.00	02000	NURSING PROGRAM	42,421	0	48	279	0	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	192,671	450,613	5,822	19,097	118,665	30.00
31.00	03100	INTENSIVE CARE UNIT	40,461	116,082	1,843	8,925	33,309	31.00
43.00	04300	NURSERY	372	1,093	0	0	1,288	43.00
44.00	04400	SKILLED NURSING FACILITY	36,536	126,716	1,161	2,963	7,231	44.00
45.00	04500	NURSING FACILITY	36,399	131,586	739	3,972	6,627	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	80,688	243,195	34,935	20,505	232,820	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	717	2,087	0	0	5,306	52.01
53.00	05300	ANESTHESIOLOGY	0	31,306	585	205	80,600	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,813	0	5,217	5,671	143,338	54.00
57.00	05700	CT SCAN	0	0	1,711	170	118,888	57.00
58.00	05800	MRI	781	0	714	0	33,825	58.00
60.00	06000	LABORATORY	79,932	0	17,246	353	234,559	60.00
65.00	06500	RESPIRATORY THERAPY	27,474	0	2,544	199	28,241	65.00
66.00	06600	PHYSICAL THERAPY	73,491	0	288	39	82,743	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	31,333	0	32,946	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	73,822	0	44,641	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	820	1,147,847	80,306	73.00
76.97	07697	CARDIAC REHABILITATION	8,525	0	183	527	10,009	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	478,000	0	8,084	340,690	161,952	88.00
88.01	08801	ELMWOOD RHC	0	0	459	19,357	5,490	88.01
88.02	08802	WILLIAMSFIELD RHC	0	0	50	2,107	472	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	17,126	0	4,846	8,720	30,573	90.01
91.00	09100	EMERGENCY	50,710	208,212	3,951	13,287	213,607	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	908	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,312,033	1,310,890	197,309	1,594,913	1,707,436	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	16	0	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	857	0	194.11
194.12	07962	AVON CLINIC	0	0	0	0	0	194.12
194.13	07963	WILLIAMSFIELD CLINIC	0	0	86	3,632	814	194.13
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,312,033	1,310,890	197,411	1,599,402	1,708,250	202.00

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COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I | Date/Time Prepared: 11/30/2023 12:56 pm

		Cost Center Description	NURSING PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			20.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING PROGRAM	3,224,909					20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,322,512	12,173,102	0	12,173,102		30.00
31.00	03100	INTENSIVE CARE UNIT	548,905	2,644,121	0	2,644,121		31.00
43.00	04300	NURSERY	0	101,121	0	101,121		43.00
44.00	04400	SKILLED NURSING FACILITY	106,670	2,257,323	0	2,257,323		44.00
45.00	04500	NURSING FACILITY	0	2,418,388	0	2,418,388		45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	412,975	7,081,820	0	7,081,820		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	69,045	0	69,045		52.01
53.00	05300	ANESTHESIOLOGY	0	175,602	0	175,602		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,520	4,074,462	0	4,074,462		54.00
57.00	05700	CT SCAN	0	841,016	0	841,016		57.00
58.00	05800	MRI	0	529,689	0	529,689		58.00
60.00	06000	LABORATORY	0	7,745,809	0	7,745,809		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,321,224	0	1,321,224		65.00
66.00	06600	PHYSICAL THERAPY	77,780	3,400,677	0	3,400,677		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,259,980	0	1,259,980		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,935,425	0	2,935,425		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,260	4,245,036	0	4,245,036		73.00
76.97	07697	CARDIAC REHABILITATION	80,743	864,482	0	864,482		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	91,003	32,745,276	0	32,745,276		88.00
88.01	08801	ELMWOOD RHC	3,326	1,861,576	0	1,861,576		88.01
88.02	08802	WILLIAMSFIELD RHC	356	215,359	0	215,359		88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	WOUND CLINIC	37,038	1,726,517	0	1,726,517		90.01
91.00	09100	EMERGENCY	465,199	4,202,289	0	4,202,289		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	2,085,928	0	2,085,928		96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,224,287	96,975,267	0	96,975,267		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	27,924	0	27,924		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	183,963	0	183,963		192.00
192.01	19201	CANTON RHC RENTED SPACE	0	396,625	0	396,625		192.01
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.02	19302	FOUNDATION	0	0	0	0		193.02
194.00	07950	PHYSICIANS CLINIC	0	142,384	0	142,384		194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0		194.01
194.02	07952	FRESENIUS	0	232,012	0	232,012		194.02
194.03	07953	RUCHFORD POB	0	21,137	0	21,137		194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	258,035	0	258,035		194.04
194.05	07955	FARMINGTON POB	0	0	0	0		194.05
194.06	07956	LEWISTON POB	0	0	0	0		194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0		194.07
194.08	07958	KELLEY HOME	0	0	0	0		194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0		194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0		194.10
194.11	07961	WELLNESS CENTER	0	166,079	0	166,079		194.11
194.12	07962	AVON CLINIC	0	0	0	0		194.12
194.13	07963	WILLIAMSFIELD CLINIC	622	371,262	0	371,262		194.13
200.00		Cross Foot Adjustments	0	0	0	0		200.00

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COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part I Date/Time Prepared: 11/30/2023 12:56 pm

	Cost Center Description	NURSING PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		20.00	24.00	25.00	26.00		
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	3,224,909	98,774,688	0	98,774,688		202.00

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ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/30/2023 12:56 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	19,371	7,213	26,584	26,584	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	463,375	172,532	635,907	5,466	5.00
7.00	00700	OPERATION OF PLANT	0	438,113	163,126	601,239	623	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	95,277	35,475	130,752	3	8.00
9.00	00900	HOUSEKEEPING	0	77,031	28,681	105,712	687	9.00
10.00	01000	DIETARY	0	69,346	25,820	95,166	238	10.00
11.00	01100	CAFETERIA	0	88,343	32,893	121,236	303	11.00
13.00	01300	NURSING ADMINISTRATION	0	37,029	13,787	50,816	393	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	51,581	19,206	70,787	0	14.00
15.00	01500	PHARMACY	0	49,975	18,608	68,583	515	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	76,040	28,313	104,353	382	16.00
20.00	02000	NURSING PROGRAM	0	438,073	163,111	601,184	582	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	339,288	126,330	465,618	2,645	30.00
31.00	03100	INTENSIVE CARE UNIT	0	33,816	12,591	46,407	555	31.00
43.00	04300	NURSERY	0	11,928	4,441	16,369	5	43.00
44.00	04400	SKILLED NURSING FACILITY	0	80,471	29,963	110,434	502	44.00
45.00	04500	NURSING FACILITY	0	70,859	26,384	97,243	500	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	269,232	100,246	369,478	1,108	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	6,305	2,348	8,653	10	52.01
53.00	05300	ANESTHESIOLOGY	0	4,217	1,570	5,787	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	94,715	35,266	129,981	711	54.00
57.00	05700	CT SCAN	0	78,517	29,235	107,752	0	57.00
58.00	05800	MRI	0	22,357	8,324	30,681	11	58.00
60.00	06000	LABORATORY	0	179,015	66,654	245,669	1,097	60.00
65.00	06500	RESPIRATORY THERAPY	0	26,507	9,870	36,377	377	65.00
66.00	06600	PHYSICAL THERAPY	0	102,560	38,187	140,747	1,009	66.00
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	37,096	13,812	50,908	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	114,997	42,818	157,815	117	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	790,962	294,508	1,085,470	6,560	88.00
88.01	08801	ELMWOOD RHC	0	45,303	16,868	62,171	373	88.01
88.02	08802	WILLIAMSFIELD RHC	0	9,358	3,484	12,842	41	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	56,387	20,995	77,382	361	90.01
91.00	09100	EMERGENCY	0	158,412	58,983	217,395	938	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	2,048	763	2,811	350	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,437,904	1,652,405	6,090,309	26,462	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	7,296	2,717	10,013	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	47,538	17,700	65,238	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	137,314	51,127	188,441	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	37,203	13,852	51,055	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	80,324	29,908	110,232	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	89,333	33,262	122,595	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	0	52	194.11
194.12	07962	AVON CLINIC	0	0	0	0	0	194.12
194.13	07963	WILLIAMSFIELD CLINIC	0	16,132	6,006	22,138	70	194.13

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ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/30/2023 12:56 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	
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	4,853,044	1,806,977	6,660,021	26,584	202.00

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ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/30/2023 12:56 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	641,373					5.00
7.00	00700	OPERATION OF PLANT	31,303	633,165				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,880	15,342	149,977			8.00
9.00	00900	HOUSEKEEPING	14,241	12,404	0	133,044		9.00
10.00	01000	DIETARY	4,655	11,166	0	3,786	115,011	10.00
11.00	01100	CAFETERIA	7,278	14,225	0	4,823	0	11.00
13.00	01300	NURSING ADMINISTRATION	7,806	5,962	0	2,022	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	557	8,306	0	2,816	0	14.00
15.00	01500	PHARMACY	9,439	8,047	0	2,728	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,843	12,244	0	4,151	0	16.00
20.00	02000	NURSING PROGRAM	14,505	70,539	0	23,918	0	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	56,896	54,633	53,761	18,523	41,227	30.00
31.00	03100	INTENSIVE CARE UNIT	11,011	5,445	11,910	1,846	9,133	31.00
43.00	04300	NURSERY	217	1,921	3,706	651	2,842	43.00
44.00	04400	SKILLED NURSING FACILITY	10,087	12,958	23,549	4,393	18,059	44.00
45.00	04500	NURSING FACILITY	9,705	11,410	56,052	3,868	42,984	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,543	43,352	0	14,698	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	239	1,015	999	344	766	52.01
53.00	05300	ANESTHESIOLOGY	349	679	0	230	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,537	15,251	0	5,171	0	54.00
57.00	05700	CT SCAN	3,573	12,643	0	4,286	0	57.00
58.00	05800	MRI	2,896	3,600	0	1,221	0	58.00
60.00	06000	LABORATORY	45,623	28,825	0	9,773	0	60.00
65.00	06500	RESPIRATORY THERAPY	7,827	4,268	0	1,447	0	65.00
66.00	06600	PHYSICAL THERAPY	19,118	16,514	0	5,599	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,764	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,291	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,034	5,973	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	4,049	18,517	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	199,321	127,358	0	0	0	88.00
88.01	08801	ELMWOOD RHC	11,541	7,295	0	0	0	88.01
88.02	08802	WILLIAMSFIELD RHC	1,305	1,507	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	9,780	9,080	0	3,078	0	90.01
91.00	09100	EMERGENCY	18,859	25,508	0	8,648	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	13,522	330	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	633,594	566,317	149,977	128,020	115,011	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	79	1,175	0	398	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	526	7,655	0	2,595	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	1,482	22,110	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	402	5,991	0	2,031	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	867	12,934	0	0	0	194.02
194.03	07953	RUCHFORD POB	137	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	964	14,385	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	1,073	0	0	0	0	194.11
194.12	07962	AVON CLINIC	0	0	0	0	0	194.12
194.13	07963	WILLIAMSFIELD CLINIC	2,249	2,598	0	0	0	194.13
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)	641,373	633,165	149,977	133,044	115,011	202.00

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ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/30/2023 12:56 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	147,865					11.00
13.00	01300	NURSING ADMINISTRATION	3,224	70,223				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	82,466			14.00
15.00	01500	PHARMACY	4,226	0	0	93,538		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,134	0	0	0	134,107	16.00
20.00	02000	NURSING PROGRAM	4,781	0	20	16	0	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,715	24,138	2,432	1,117	9,312	30.00
31.00	03100	INTENSIVE CARE UNIT	4,560	6,218	770	522	2,614	31.00
43.00	04300	NURSERY	42	59	0	0	101	43.00
44.00	04400	SKILLED NURSING FACILITY	4,118	6,788	485	173	567	44.00
45.00	04500	NURSING FACILITY	4,102	7,049	309	232	520	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,094	13,028	14,594	1,199	18,270	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	81	112	0	0	416	52.01
53.00	05300	ANESTHESIOLOGY	0	1,677	245	12	6,325	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,839	0	2,179	332	11,248	54.00
57.00	05700	CT SCAN	0	0	715	10	9,329	57.00
58.00	05800	MRI	88	0	298	0	2,654	58.00
60.00	06000	LABORATORY	9,009	0	7,204	21	18,465	60.00
65.00	06500	RESPIRATORY THERAPY	3,096	0	1,063	12	2,216	65.00
66.00	06600	PHYSICAL THERAPY	8,283	0	120	2	6,493	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	13,089	0	2,585	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	30,837	0	3,503	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	342	67,130	6,302	73.00
76.97	07697	CARDIAC REHABILITATION	961	0	77	31	785	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	53,867	0	3,377	19,925	12,709	88.00
88.01	08801	ELMWOOD RHC	0	0	192	1,132	431	88.01
88.02	08802	WILLIAMSFIELD RHC	0	0	21	123	37	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	1,930	0	2,025	510	2,399	90.01
91.00	09100	EMERGENCY	5,715	11,154	1,650	777	16,762	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	379	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	147,865	70,223	82,423	93,276	134,043	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	7	0	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	50	0	194.11
194.12	07962	AVON CLINIC	0	0	0	0	0	194.12
194.13	07963	WILLIAMSFIELD CLINIC	0	0	36	212	64	194.13
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)	147,865	70,223	82,466	93,538	134,107	202.00

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ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II | Date/Time Prepared: 11/30/2023 12:56 pm

		Cost Center Description	NURSING PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			20.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING PROGRAM	715,545					20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		752,017	0	752,017		30.00
31.00	03100	INTENSIVE CARE UNIT		100,991	0	100,991		31.00
43.00	04300	NURSERY		25,913	0	25,913		43.00
44.00	04400	SKILLED NURSING FACILITY		192,113	0	192,113		44.00
45.00	04500	NURSING FACILITY		233,974	0	233,974		45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		520,364	0	520,364		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0		52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM		12,635	0	12,635		52.01
53.00	05300	ANESTHESIOLOGY		15,304	0	15,304		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		194,249	0	194,249		54.00
57.00	05700	CT SCAN		138,308	0	138,308		57.00
58.00	05800	MRI		41,449	0	41,449		58.00
60.00	06000	LABORATORY		365,686	0	365,686		60.00
65.00	06500	RESPIRATORY THERAPY		56,683	0	56,683		65.00
66.00	06600	PHYSICAL THERAPY		197,885	0	197,885		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		23,438	0	23,438		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		52,631	0	52,631		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		149,689	0	149,689		73.00
76.97	07697	CARDIAC REHABILITATION		182,352	0	182,352		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		1,508,587	0	1,508,587		88.00
88.01	08801	ELMWOOD RHC		83,135	0	83,135		88.01
88.02	08802	WILLIAMSFIELD RHC		15,876	0	15,876		88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0		89.00
90.00	09000	CLINIC		0	0	0		90.00
90.01	09001	WOUND CLINIC		106,545	0	106,545		90.01
91.00	09100	EMERGENCY		307,406	0	307,406		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		17,392	0	17,392		96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,294,622	0	5,294,622		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN		11,665	0	11,665		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES		76,021	0	76,021		192.00
192.01	19201	CANTON RHC RENTED SPACE		212,033	0	212,033		192.01
193.00	19300	NONPAID WORKERS		0	0	0		193.00
193.02	19302	FOUNDATION		0	0	0		193.02
194.00	07950	PHYSICIANS CLINIC		59,479	0	59,479		194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY		0	0	0		194.01
194.02	07952	FRESENIUS		124,033	0	124,033		194.02
194.03	07953	RUCHFORD POB		137	0	137		194.03
194.04	07954	EP COLEMAN RENTAL SPACE		137,944	0	137,944		194.04
194.05	07955	FARMINGTON POB		0	0	0		194.05
194.06	07956	LEWISTON POB		0	0	0		194.06
194.07	07957	OTHER RENTAL PROPERTY		0	0	0		194.07
194.08	07958	KELLEY HOME		0	0	0		194.08
194.09	07959	EMPLOYEE PURCHASE		0	0	0		194.09
194.10	07960	RETAIL PHARMACY		0	0	0		194.10
194.11	07961	WELLNESS CENTER		1,175	0	1,175		194.11
194.12	07962	AVON CLINIC		0	0	0		194.12
194.13	07963	WILLIAMSFIELD CLINIC		27,367	0	27,367		194.13
200.00		Cross Foot Adjustments	715,545	715,545	0	715,545		200.00

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ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B Part II Date/Time Prepared: 11/30/2023 12:56 pm

	Cost Center Description	NURSING PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		20.00	24.00	25.00	26.00		
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	715,545	6,660,021	0	6,660,021		202.00

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COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/30/2023 12:56 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	362,511					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		362,511				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,447	1,447	46,151,499			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	34,613	34,613	9,489,474	-17,237,833	81,536,855	5.00
7.00	00700	OPERATION OF PLANT	32,726	32,726	1,081,258	0	3,979,508	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,117	7,117	4,385	0	493,301	8.00
9.00	00900	HOUSEKEEPING	5,754	5,754	1,193,257	0	1,810,498	9.00
10.00	01000	DIETARY	5,180	5,180	412,999	0	591,832	10.00
11.00	01100	CAFETERIA	6,599	6,599	526,062	0	925,198	11.00
13.00	01300	NURSING ADMINISTRATION	2,766	2,766	681,707	0	992,335	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,853	3,853	0	0	70,787	14.00
15.00	01500	PHARMACY	3,733	3,733	893,700	0	1,200,021	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,680	5,680	662,814	0	1,251,294	16.00
20.00	02000	NURSING PROGRAM	32,723	32,723	1,010,979	0	1,844,010	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,344	25,344	4,591,787	0	7,233,182	30.00
31.00	03100	INTENSIVE CARE UNIT	2,526	2,526	964,284	0	1,399,860	31.00
43.00	04300	NURSERY	891	891	8,873	0	27,626	43.00
44.00	04400	SKILLED NURSING FACILITY	6,011	6,011	870,727	0	1,282,412	44.00
45.00	04500	NURSING FACILITY	5,293	5,293	867,465	0	1,233,790	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,111	20,111	1,922,906	0	4,518,603	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	471	471	17,090	0	30,334	52.01
53.00	05300	ANESTHESIOLOGY	315	315	0	0	44,392	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,075	7,075	1,234,807	0	2,992,269	54.00
57.00	05700	CT SCAN	5,865	5,865	0	0	454,247	57.00
58.00	05800	MRI	1,670	1,670	18,620	0	368,143	58.00
60.00	06000	LABORATORY	13,372	13,372	1,904,962	0	5,800,009	60.00
65.00	06500	RESPIRATORY THERAPY	1,980	1,980	654,771	0	995,026	65.00
66.00	06600	PHYSICAL THERAPY	7,661	7,661	1,751,446	0	2,430,488	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	987,031	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,325,354	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,771	2,771	0	0	2,419,757	73.00
76.97	07697	CARDIAC REHABILITATION	8,590	8,590	203,026	0	514,697	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	59,083	59,083	11,391,436	0	25,338,921	88.00
88.01	08801	ELMWOOD RHC	3,384	3,384	647,209	0	1,467,216	88.01
88.02	08802	WILLIAMSFIELD RHC	699	699	70,476	0	165,841	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	4,212	4,212	626,515	0	1,243,302	90.01
91.00	09100	EMERGENCY	11,833	11,833	1,628,411	0	2,397,537	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	153	153	607,618	0	1,719,076	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	331,501	331,501	45,939,064	-17,237,833	80,547,897	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	545	545	0	0	10,013	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	3,551	3,551	463	0	66,896	192.00
192.01	19201	CANTON RHC RENTED SPACE	10,257	10,257	0	0	188,441	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	2,779	2,779	0	0	51,055	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	6,000	6,000	0	0	110,232	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	17,448	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	6,673	6,673	0	0	122,595	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	90,479	0	136,388	194.11
194.12	07962	AVON CLINIC	0	0	0	0	0	194.12

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COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/30/2023 12:56 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
194.13	07963	WILLIAMSFIELD CLINIC	1,205	1,205	121,493	0	285,890	194.13
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)	4,853,044	1,806,977	12,397,882		17,237,833	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.387301	4.984613	0.268634		0.211412	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			26,584		641,373	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000576		0.007866	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

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COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/30/2023 12:56 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	293,725					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,117	14,406				8.00
9.00	00900	HOUSEKEEPING	5,754	0	182,039			9.00
10.00	01000	DIETARY	5,180	0	5,180	14,406		10.00
11.00	01100	CAFETERIA	6,599	0	6,599	0	31,268,304	11.00
13.00	01300	NURSING ADMINISTRATION	2,766	0	2,766	0	681,707	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,853	0	3,853	0	0	14.00
15.00	01500	PHARMACY	3,733	0	3,733	0	893,700	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,680	0	5,680	0	662,814	16.00
20.00	02000	NURSING PROGRAM	32,723	0	32,723	0	1,010,979	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,344	5,164	25,344	5,164	4,591,787	30.00
31.00	03100	INTENSIVE CARE UNIT	2,526	1,144	2,526	1,144	964,284	31.00
43.00	04300	NURSERY	891	356	891	356	8,873	43.00
44.00	04400	SKILLED NURSING FACILITY	6,011	2,262	6,011	2,262	870,727	44.00
45.00	04500	NURSING FACILITY	5,293	5,384	5,293	5,384	867,465	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,111	0	20,111	0	1,922,984	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	471	96	471	96	17,090	52.01
53.00	05300	ANESTHESIOLOGY	315	0	315	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,075	0	7,075	0	1,234,807	54.00
57.00	05700	CT SCAN	5,865	0	5,865	0	0	57.00
58.00	05800	MRI	1,670	0	1,670	0	18,620	58.00
60.00	06000	LABORATORY	13,372	0	13,372	0	1,904,962	60.00
65.00	06500	RESPIRATORY THERAPY	1,980	0	1,980	0	654,771	65.00
66.00	06600	PHYSICAL THERAPY	7,661	0	7,661	0	1,751,446	66.00
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	2,771	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	8,590	0	0	0	203,170	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	59,083	0	0	0	11,391,436	88.00
88.01	08801	ELMWOOD RHC	3,384	0	0	0	0	88.01
88.02	08802	WILLIAMSFIELD RHC	699	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	4,212	0	4,212	0	408,153	90.01
91.00	09100	EMERGENCY	11,833	0	11,833	0	1,208,529	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	153	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	262,715	14,406	175,164	14,406	31,268,304	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	545	0	545	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	3,551	0	3,551	0	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	10,257	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	2,779	0	2,779	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	6,000	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	6,673	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	0	0	194.11
194.12	07962	AVON CLINIC	0	0	0	0	0	194.12
194.13	07963	WILLIAMSFIELD CLINIC	1,205	0	0	0	0	194.13
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

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COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/30/2023 12:56 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	4,820,824	714,400	2,287,698	867,067	1,312,033	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.412713	49.590448	12.567076	60.187908	0.041960	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	633,165	149,977	133,044	115,011	147,865	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.155639	10.410732	0.730854	7.983549	0.004729	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

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COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/30/2023 12:56 pm

		Cost Center Description	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NURSING PROGRAM (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	20.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	13,190					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,218,657				14.00
15.00	01500	PHARMACY	0	0	3,267,003			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	268,653,301		16.00
20.00	02000	NURSING PROGRAM	0	1,516	570	0	435,350	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,534	183,412	39,008	18,661,024	178,534	30.00
31.00	03100	INTENSIVE CARE UNIT	1,168	58,061	18,231	5,238,075	74,100	31.00
43.00	04300	NURSERY	11	0	0	202,555	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,275	36,588	6,052	1,137,182	14,400	44.00
45.00	04500	NURSING FACILITY	1,324	23,288	8,113	1,042,154	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,447	1,100,486	41,885	36,612,743	55,750	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	21	0	0	834,415	0	52.01
53.00	05300	ANESTHESIOLOGY	315	18,442	418	12,674,970	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	164,334	11,583	22,541,009	5,200	54.00
57.00	05700	CT SCAN	0	53,900	348	18,696,015	0	57.00
58.00	05800	MRI	0	22,501	0	5,319,271	0	58.00
60.00	06000	LABORATORY	0	543,272	722	36,904,058	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	80,138	406	4,441,158	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,076	79	13,011,960	10,500	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	987,031	0	5,181,055	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,325,354	0	7,020,200	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,820	2,344,636	12,628,698	5,300	73.00
76.97	07697	CARDIAC REHABILITATION	0	5,775	1,077	1,574,036	10,900	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	254,664	695,908	25,468,092	12,285	88.00
88.01	08801	ELMWOOD RHC	0	14,470	39,540	863,288	449	88.01
88.02	08802	WILLIAMSFIELD RHC	0	1,575	4,304	74,231	48	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	152,667	17,812	4,807,884	5,000	90.01
91.00	09100	EMERGENCY	2,095	124,458	27,141	33,591,263	62,800	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	28,608	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,190	6,215,436	3,257,833	268,525,336	435,266	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	506	0	0	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	1,751	0	0	194.11
194.12	07962	AVON CLINIC	0	0	0	0	0	194.12
194.13	07963	WILLIAMSFIELD CLINIC	0	2,715	7,419	127,965	84	194.13
200.00		Cross Foot Adjustments						200.00

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COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet B-1 | Date/Time Prepared: 11/30/2023 12:56 pm

		Cost Center Description	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NURSING PROGRAM (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	20.00	
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,310,890	197,411	1,599,402	1,708,250	3,224,909	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	99.385140	0.031745	0.489562	0.006359	7.407624	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	70,223	82,466	93,538	134,107	715,545	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.323958	0.013261	0.028631	0.000499	1.643609	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

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COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/30/2023 12:56 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,173,102		12,173,102	0	12,173,102	30.00
31.00	03100	INTENSIVE CARE UNIT	2,644,121		2,644,121	0	2,644,121	31.00
43.00	04300	NURSERY	101,121		101,121	0	101,121	43.00
44.00	04400	SKILLED NURSING FACILITY	2,257,323		2,257,323	0	2,257,323	44.00
45.00	04500	NURSING FACILITY	2,418,388		2,418,388	0	2,418,388	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,081,820		7,081,820	0	7,081,820	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	69,045		69,045	0	69,045	52.01
53.00	05300	ANESTHESIOLOGY	175,602		175,602	0	175,602	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,074,462		4,074,462	0	4,074,462	54.00
57.00	05700	CT SCAN	841,016		841,016	0	841,016	57.00
58.00	05800	MRI	529,689		529,689	0	529,689	58.00
60.00	06000	LABORATORY	7,745,809		7,745,809	15,798	7,761,607	60.00
65.00	06500	RESPIRATORY THERAPY	1,321,224	0	1,321,224	0	1,321,224	65.00
66.00	06600	PHYSICAL THERAPY	3,400,677	0	3,400,677	0	3,400,677	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,259,980		1,259,980	0	1,259,980	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,935,425		2,935,425	0	2,935,425	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,245,036		4,245,036	0	4,245,036	73.00
76.97	07697	CARDIAC REHABILITATION	864,482		864,482	0	864,482	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	32,745,276		32,745,276	0	32,745,276	88.00
88.01	08801	ELMWOOD RHC	1,861,576		1,861,576	0	1,861,576	88.01
88.02	08802	WILLIAMSFIELD RHC	215,359		215,359	0	215,359	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,726,517		1,726,517	24,134	1,750,651	90.01
91.00	09100	EMERGENCY	4,202,289		4,202,289	391,678	4,593,967	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,865,737		2,865,737		2,865,737	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2,085,928		2,085,928	0	2,085,928	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	99,841,004	0	99,841,004	431,610	100,272,614	200.00
201.00		Less Observation Beds	2,865,737		2,865,737		2,865,737	201.00
202.00		Total (see instructions)	96,975,267	0	96,975,267	431,610	97,406,877	202.00

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COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/30/2023 12:56 pm

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		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	12,236,702		12,236,702			30.00
31.00	03100	INTENSIVE CARE UNIT	5,238,075		5,238,075			31.00
43.00	04300	NURSERY	202,555		202,555			43.00
44.00	04400	SKILLED NURSING FACILITY	1,137,182		1,137,182			44.00
45.00	04500	NURSING FACILITY	1,042,154		1,042,154			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,317,712	29,295,031	36,612,743	0.193425	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	826,777	7,638	834,415	0.082747	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	3,004,008	9,670,962	12,674,970	0.013854	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,805,274	20,735,735	22,541,009	0.180758	0.000000	54.00
57.00	05700	CT SCAN	2,218,446	16,477,569	18,696,015	0.044984	0.000000	57.00
58.00	05800	MRI	268,755	5,050,515	5,319,270	0.099579	0.000000	58.00
60.00	06000	LABORATORY	4,997,270	31,906,788	36,904,058	0.209890	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,616,436	2,824,722	4,441,158	0.297495	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,815,363	11,196,597	13,011,960	0.261350	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,907,587	2,273,468	5,181,055	0.243190	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,125,364	3,894,837	7,020,201	0.418140	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,288,012	6,340,686	12,628,698	0.336142	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	13,775	1,560,262	1,574,037	0.549213	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	25,468,092	25,468,092			88.00
88.01	08801	ELMWOOD RHC	0	863,288	863,288			88.01
88.02	08802	WILLIAMSFIELD RHC	0	74,231	74,231			88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CLINIC	22,511	4,785,372	4,807,883	0.359101	0.000000	90.01
91.00	09100	EMERGENCY	5,205,850	28,385,413	33,591,263	0.125101	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,948,768	4,475,554	6,424,322	0.446076	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	4,140,892	4,140,892	0.503739	0.000000	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	63,238,576	209,427,652	272,666,228			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	63,238,576	209,427,652	272,666,228			202.00

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COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet C Part I Date/Time Prepared: 11/30/2023 12:56 pm

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		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
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.193425		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.082747		52.01
53.00	05300	ANESTHESIOLOGY	0.013854		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180758		54.00
57.00	05700	CT SCAN	0.044984		57.00
58.00	05800	MRI	0.099579		58.00
60.00	06000	LABORATORY	0.210319		60.00
65.00	06500	RESPIRATORY THERAPY	0.297495		65.00
66.00	06600	PHYSICAL THERAPY	0.261350		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.243190		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.418140		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.336142		73.00
76.97	07697	CARDIAC REHABILITATION	0.549213		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	ELMWOOD RHC			88.01
88.02	08802	WILLIAMSFIELD RHC			88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CLINIC	0.364121		90.01
91.00	09100	EMERGENCY	0.136761		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.446076		92.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.503739		96.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part I | Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	752,017	0	752,017	6,754	111.34	30.00
31.00	INTENSIVE CARE UNIT	100,991		100,991	1,144	88.28	31.00
43.00	NURSERY	25,913		25,913	356	72.79	43.00
44.00	SKILLED NURSING FACILITY	192,113		192,113	2,262	84.93	44.00
45.00	NURSING FACILITY	233,974		233,974	5,384	43.46	45.00
200.00	Total (lines 30 through 199)	1,305,008		1,305,008	15,900		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	2,427	270,222		30.00
31.00	INTENSIVE CARE UNIT	477	42,110		31.00
43.00	NURSERY	0	0		43.00
44.00	SKILLED NURSING FACILITY	1,308	111,088		44.00
45.00	NURSING FACILITY	0	0		45.00
200.00	Total (lines 30 through 199)	4,212	423,420		200.00

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part II Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	520,364	36,612,743	0.014213	3,059,232	43,481	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	12,635	834,415	0.015142	0	0	52.01
53.00	05300	ANESTHESIOLOGY	15,304	12,674,970	0.001207	775,263	936	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	194,249	22,541,009	0.008618	801,252	6,905	54.00
57.00	05700	CT SCAN	138,308	18,696,015	0.007398	996,779	7,374	57.00
58.00	05800	MRI	41,449	5,319,270	0.007792	116,042	904	58.00
60.00	06000	LABORATORY	365,686	36,904,058	0.009909	2,036,431	20,179	60.00
65.00	06500	RESPIRATORY THERAPY	56,683	4,441,158	0.012763	966,490	12,335	65.00
66.00	06600	PHYSICAL THERAPY	197,885	13,011,960	0.015208	933,455	14,196	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,438	5,181,055	0.004524	1,243,866	5,627	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,631	7,020,201	0.007497	1,420,278	10,648	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	149,689	12,628,698	0.011853	2,511,640	29,770	73.00
76.97	07697	CARDIAC REHABILITATION	182,352	1,574,037	0.115850	8,035	931	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,508,587	25,468,092	0.059234	0	0	88.00
88.01	08801	ELMWOOD RHC	83,135	863,288	0.096300	0	0	88.01
88.02	08802	WILLIAMSFIELD RHC	15,876	74,231	0.213873	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	106,545	4,807,883	0.022160	15,092	334	90.01
91.00	09100	EMERGENCY	307,406	33,591,263	0.009151	2,432,209	22,257	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	177,037	6,424,322	0.027557	995,477	27,432	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	17,392	4,140,892	0.004200	0	0	96.00
200.00		Total (lines 50 through 199)	4,166,651	252,809,560		18,311,541	203,309	200.00

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part III Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,322,512	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	548,905	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	106,670	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
200.00		Total (lines 30 through 199)	0	1,978,087	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,322,512	6,754	195.81	2,427	30.00
31.00	03100	INTENSIVE CARE UNIT		548,905	1,144	479.81	477	31.00
43.00	04300	NURSERY		0	356	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		106,670	2,262	47.16	1,308	44.00
45.00	04500	NURSING FACILITY		0	5,384	0.00	0	45.00
200.00		Total (lines 30 through 199)		1,978,087	15,900		4,212	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
			9.00					
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	475,231					30.00
31.00	03100	INTENSIVE CARE UNIT	228,869					31.00
43.00	04300	NURSERY	0					43.00
44.00	04400	SKILLED NURSING FACILITY	61,685					44.00
45.00	04500	NURSING FACILITY	0					45.00
200.00		Total (lines 30 through 199)	765,785					200.00

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	412,975	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	38,520	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	77,780	0	0	66.00
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	39,260	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	80,743	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	91,003	0	0	88.00
88.01	08801	ELMWOOD RHC	0	0	3,326	0	0	88.01
88.02	08802	WILLIAMSFIELD RHC	0	0	356	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	37,038	0	0	90.01
91.00	09100	EMERGENCY	0	0	465,199	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		311,339		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	1,557,539	0	0	200.00

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	412,975	412,975	36,612,743	0.011280	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0	0	834,415	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	12,674,970	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	38,520	38,520	22,541,009	0.001709	54.00
57.00	05700	CT SCAN	0	0	0	18,696,015	0.000000	57.00
58.00	05800	MRI	0	0	0	5,319,270	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	36,904,058	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,441,158	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	77,780	77,780	13,011,960	0.005978	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,181,055	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,020,201	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	39,260	39,260	12,628,698	0.003109	73.00
76.97	07697	CARDIAC REHABILITATION	0	80,743	80,743	1,574,037	0.051297	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	91,003	91,003	25,468,092	0.003573	88.00
88.01	08801	ELMWOOD RHC	0	3,326	3,326	863,288	0.003853	88.01
88.02	08802	WILLIAMSFIELD RHC	0	356	356	74,231	0.004796	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CLINIC	0	37,038	37,038	4,807,883	0.007704	90.01
91.00	09100	EMERGENCY	0	465,199	465,199	33,591,263	0.013849	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	311,339	311,339	6,424,322	0.048463	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	4,140,892	0.000000	96.00
200.00		Total (lines 50 through 199)	0	1,557,539	1,557,539	252,809,560		200.00

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.011280	3,059,232	34,508	5,263,823	59,376	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.000000	775,263	0	1,196,407	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.001709	801,252	1,369	4,834,203	8,262	54.00
57.00	05700	CT SCAN	0.000000	996,779	0	4,388,842	0	57.00
58.00	05800	MRI	0.000000	116,042	0	1,037,358	0	58.00
60.00	06000	LABORATORY	0.000000	2,036,431	0	2,983,500	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	966,490	0	486,718	0	65.00
66.00	06600	PHYSICAL THERAPY	0.005978	933,455	5,580	36,834	220	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,243,866	0	336,274	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,420,278	0	995,902	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.003109	2,511,640	7,809	1,502,588	4,672	73.00
76.97	07697	CARDIAC REHABILITATION	0.051297	8,035	412	686,089	35,194	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.003573	0	0	0	0	88.00
88.01	08801	ELMWOOD RHC	0.003853	0	0	0	0	88.01
88.02	08802	WILLIAMSFIELD RHC	0.004796	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.007704	15,092	116	1,538,516	11,853	90.01
91.00	09100	EMERGENCY	0.013849	2,432,209	33,684	5,446,210	75,425	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.048463	995,477	48,244	1,591,466	77,127	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		18,311,541	131,722	32,324,730	272,129	200.00

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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.193425	5,263,823	0	0	1,018,155	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.082747	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.013854	1,196,407	0	0	16,575	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180758	4,834,203	0	0	873,821	54.00
57.00	05700	CT SCAN	0.044984	4,388,842	0	0	197,428	57.00
58.00	05800	MRI	0.099579	1,037,358	0	0	103,299	58.00
60.00	06000	LABORATORY	0.209890	2,983,500	0	0	626,207	60.00
65.00	06500	RESPIRATORY THERAPY	0.297495	486,718	0	0	144,796	65.00
66.00	06600	PHYSICAL THERAPY	0.261350	36,834	0	0	9,627	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.243190	336,274	0	0	81,778	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.418140	995,902	0	0	416,426	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.336142	1,502,588	0	2,250	505,083	73.00
76.97	07697	CARDIAC REHABILITATION	0.549213	686,089	0	0	376,809	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	ELMWOOD RHC						88.01
88.02	08802	WILLIAMSFIELD RHC						88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.359101	1,538,516	0	0	552,483	90.01
91.00	09100	EMERGENCY	0.125101	5,446,210	0	0	681,326	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.446076	1,591,466	0	0	709,915	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.503739	0	0	0	0	96.00
200.00		Subtotal (see instructions)		32,324,730	0	2,250	6,313,728	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		32,324,730	0	2,250	6,313,728	202.00

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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0		52.01
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	756		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	ELMWOOD RHC				88.01
88.02	08802	WILLIAMSFIELD RHC				88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	756		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	756		202.00

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0001 Component CCN: 14-5572 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	412,975	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	38,520	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	77,780	0	0	66.00
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	39,260	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	80,743	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	91,003	0	0	88.00
88.01	08801	ELMWOOD RHC	0	0	3,326	0	0	88.01
88.02	08802	WILLIAMSFIELD RHC	0	0	356	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	37,038	0	0	90.01
91.00	09100	EMERGENCY	0	0	465,199	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	1,246,200	0	0	200.00

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0001 | Component CCN: 14-5572 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	412,975	412,975	36,612,743	0.011280	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0	0	834,415	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	12,674,970	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	38,520	38,520	22,541,009	0.001709	54.00
57.00	05700	CT SCAN	0	0	0	18,696,015	0.000000	57.00
58.00	05800	MRI	0	0	0	5,319,270	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	36,904,058	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,441,158	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	77,780	77,780	13,011,960	0.005978	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,181,055	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,020,201	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	39,260	39,260	12,628,698	0.003109	73.00
76.97	07697	CARDIAC REHABILITATION	0	80,743	80,743	1,574,037	0.051297	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	91,003	91,003	25,468,092	0.003573	88.00
88.01	08801	ELMWOOD RHC	0	3,326	3,326	863,288	0.003853	88.01
88.02	08802	WILLIAMSFIELD RHC	0	356	356	74,231	0.004796	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CLINIC	0	37,038	37,038	4,807,883	0.007704	90.01
91.00	09100	EMERGENCY	0	465,199	465,199	33,591,263	0.013849	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	6,424,322	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	4,140,892	0.000000	96.00
200.00		Total (lines 50 through 199)	0	1,246,200	1,246,200	252,809,560		200.00

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0001 | Component CCN: 14-5572 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part IV | Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.011280	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.000000	216	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.001709	7,097	12	0	0	54.00
57.00	05700	CT SCAN	0.000000	111	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	28,828	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	14,559	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.005978	859,405	5,138	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	233,531	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.003109	143,009	445	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.051297	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.003573	0	0	0	0	88.00
88.01	08801	ELMWOOD RHC	0.003853	0	0	0	0	88.01
88.02	08802	WILLIAMSFIELD RHC	0.004796	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.007704	4,826	37	0	0	90.01
91.00	09100	EMERGENCY	0.013849	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		1,291,582	5,632	0	0	200.00

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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0001 | Component CCN: 14-5572 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V | Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.193425	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.082747	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.013854	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180758	0	0	0	0	54.00
57.00	05700	CT SCAN	0.044984	0	0	0	0	57.00
58.00	05800	MRI	0.099579	0	0	0	0	58.00
60.00	06000	LABORATORY	0.209890	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.297495	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.261350	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.243190	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.418140	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.336142	0	0	352	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.549213	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	ELMWOOD RHC						88.01
88.02	08802	WILLIAMSFIELD RHC						88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.359101	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.125101	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.446076	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.503739	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	0	352	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	352	0	202.00

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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0001 | Component CCN: 14-5572 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D Part V | Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0		52.01
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	118		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	ELMWOOD RHC				88.01
88.02	08802	WILLIAMSFIELD RHC				88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	118		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	118		202.00

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COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0001	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/30/2023 12:56 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,754	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,754	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,164	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2,427	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	12,173,102	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,173,102	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	12,173,102	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,802.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,374,303	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)	4,374,303	41.00

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COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,644,121	1,144	2,311.29	477	1,102,485	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)	4,290,719	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)	9,767,507	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)	1,016,432	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	335,031	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,351,463	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,416,044	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,590	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,802.35	88.00

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COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0001	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/30/2023 12:56 pm
	Title XVIII	Hospital	PPS

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,865,737	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	752,017	12,173,102	0.061777	2,865,737	177,037	90.00
91.00	Nursing Program cost	1,322,512	12,173,102	0.108642	2,865,737	311,339	91.00
92.00	Allied health cost	0	12,173,102	0.000000	2,865,737	0	92.00
93.00	All other Medical Education	0	12,173,102	0.000000	2,865,737	0	93.00

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COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0001 Component CCN: 14-5572	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/30/2023 12:56 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,262	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,262	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,262	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,308	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,257,323	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,257,323	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,257,323	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

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COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0001 | Component CCN: 14-5572 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-1 | Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)		48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
55.01	Permanent adjustment amount per discharge		55.01
55.02	Adjustment amount per discharge (contractor use only)		55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)		59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)		60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,257,323	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	997.93	71.00
72.00	Program routine service cost (line 9 x line 71)	1,305,292	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,305,292	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,305,292	83.00
84.00	Program inpatient ancillary services (see instructions)	342,910	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	1,648,202	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00

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COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0001 Component CCN: 14-5572	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/30/2023 12:56 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description		
		1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

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

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,153,634		30.00
31.00	03100	INTENSIVE CARE UNIT		1,633,470		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.193425	3,059,232	591,732	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.082747	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.013854	775,263	10,740	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180758	801,252	144,833	54.00
57.00	05700	CT SCAN	0.044984	996,779	44,839	57.00
58.00	05800	MRI	0.099579	116,042	11,555	58.00
60.00	06000	LABORATORY	0.210319	2,036,431	428,300	60.00
65.00	06500	RESPIRATORY THERAPY	0.297495	966,490	287,526	65.00
66.00	06600	PHYSICAL THERAPY	0.261350	933,455	243,958	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.243190	1,243,866	302,496	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.418140	1,420,278	593,875	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.336142	2,511,640	844,268	73.00
76.97	07697	CARDIAC REHABILITATION	0.549213	8,035	4,413	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	ELMWOOD RHC	0.000000		0	88.01
88.02	08802	WILLIAMSFIELD RHC	0.000000		0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.364121	15,092	5,495	90.01
91.00	09100	EMERGENCY	0.136761	2,432,209	332,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.446076	995,477	444,058	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.503739	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		18,311,541	4,290,719	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)		18,311,541		202.00

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0001 | Component CCN: 14-5572 | Period: From 07/01/2022 To 06/30/2023 | Worksheet D-3 | Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.193425	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.082747	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.013854	216	3	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180758	7,097	1,283	54.00
57.00	05700	CT SCAN	0.044984	111	5	57.00
58.00	05800	MRI	0.099579	0	0	58.00
60.00	06000	LABORATORY	0.210319	28,828	6,063	60.00
65.00	06500	RESPIRATORY THERAPY	0.297495	14,559	4,331	65.00
66.00	06600	PHYSICAL THERAPY	0.261350	859,405	224,605	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.243190	233,531	56,792	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.418140	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.336142	143,009	48,071	73.00
76.97	07697	CARDIAC REHABILITATION	0.549213	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	ELMWOOD RHC	0.000000		0	88.01
88.02	08802	WILLIAMSFIELD RHC	0.000000		0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.364121	4,826	1,757	90.01
91.00	09100	EMERGENCY	0.136761	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.446076	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.503739	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,291,582	342,910	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)		1,291,582		202.00

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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0001	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part A Date/Time Prepared: 11/30/2023 12:56 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,417,514	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,922,522	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	16,527	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	13,792	2.04
3.00	Managed Care Simulated Payments	2,958,940	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	38.64	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.86	30.00
31.00	Percentage of Medicaid patient days (see instructions)	20.89	31.00
32.00	Sum of lines 30 and 31	24.75	32.00
33.00	Allowable disproportionate share percentage (see instructions)	9.63	33.00

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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0001	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part A Date/Time Prepared: 11/30/2023 12:56 pm
	Title XVIII	Hospital	PPS

			1.00	
34.00	Disproportionate share adjustment (see instructions)		128,562	34.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	7,192,008,710	6,874,403,459	35.00
35.01	Factor 3 (see instructions)	0.000099299	0.000098479	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	714,159	676,984	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	180,007	506,347	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	686,354		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	6,185,271		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	6,652,656		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		6,652,656	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		398,268	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		495,237	53.00
54.00	Special add-on payments for new technologies		39,809	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
55.01	Cellular therapy acquisition cost (see instructions)		0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		704,100	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		131,722	58.00
59.00	Total (sum of amounts on lines 49 through 58)		8,421,792	59.00
60.00	Primary payer payments		11,777	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		8,410,015	61.00
62.00	Deductibles billed to program beneficiaries		780,428	62.00
63.00	Coinsurance billed to program beneficiaries		12,323	63.00
64.00	Allowable bad debts (see instructions)		228,389	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		148,453	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		159,568	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		7,765,717	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0	70.75
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		0	70.93
70.94	HRR adjustment amount (see instructions)		-44,619	70.94
70.95	Recovery of accelerated depreciation		0	70.95

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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0001	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part A Date/Time Prepared: 11/30/2023 12:56 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2022	268,588	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2023	741,842	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		8,731,528	71.00
71.01	Sequestration adjustment (see instructions)		174,631	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		9,305,317	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-748,420	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		38,892	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		3,834	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	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 inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

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LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,417,514	0	1,417,514		1,417,514	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,922,522	0		3,922,522	3,922,522	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	16,527	0	16,527		16,527	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	13,792	0		13,792	13,792	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	2,958,940	0	0	2,958,940	2,958,940	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0963	0.0963	0.0963	0.0963		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	128,562	0	34,127	94,435	128,562	11.00
11.01	Uncompensated care payments	36.00	686,354	0	180,007	506,347	686,354	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,185,271	0	1,648,175	4,537,096	6,185,271	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	6,652,656	0	1,778,163	4,874,493	6,652,656	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,652,656	0	1,778,163	4,874,493	6,652,656	15.00

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LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	398,268	0	106,662	291,606	398,268	16.00
17.00	Special add-on payments for new technologies	54.00	39,809	0	0	39,809	39,809	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	1,884,825	5,205,908	7,090,733	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	396,051	0	105,441	290,610	396,051	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	2,217	0	1,221	996	2,217	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	398,268	0	106,662	291,606	398,268	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.142500	0.142500		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			268,588		268,588	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				741,842	741,842	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0001	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/30/2023 12:56 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	756	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,041,599	2.00
3.00	OPPS or REH payments	5,478,376	3.00
4.00	Outlier payment (see instructions)	7,471	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.862	5.00
6.00	Line 2 times line 5	5,207,858	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	272,129	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	756	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	2,250	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)	2,250	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)	2,250	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,494	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)	756	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)	5,757,976	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	96,108	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,010,814	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)	4,651,810	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)	4,651,810	30.00
31.00	Primary payer payments	368	31.00
32.00	Subtotal (line 30 minus line 31)	4,651,442	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)	236,798	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	153,919	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	159,461	36.00
37.00	Subtotal (see instructions)	4,805,361	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)	4,805,361	40.00
40.01	Sequestration adjustment (see instructions)	96,107	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	4,872,762	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)	-163,508	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)	327	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

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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0001	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/30/2023 12:56 pm
	Title XVIII	Hospital	PPS

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0001 Component CCN: 14-5572	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/30/2023 12:56 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	118	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments		3.00
4.00	Outlier payment (see instructions)		4.00
4.01	Outlier reconciliation amount (see instructions)		4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		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)	118	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	352	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)	352	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)	352	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	234	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)	118	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)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		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)	118	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)	118	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	118	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	118	37.00
38.00	MSP-LCC reconciliation amount from PS&R		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)	118	40.00
40.01	Sequestration adjustment (see instructions)	2	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	107	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)	9	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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00

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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0001 Component CCN: 14-5572	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/30/2023 12:56 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		9,122,146		4,942,726	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	02/22/2023	365,114		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	09/21/2022	181,943	02/22/2023	69,964	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		183,171		-69,964	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)		9,305,317		4,872,762	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		748,420		163,508	6.02
7.00	Total Medicare program liability (see instructions)		8,556,897		4,709,254	7.00

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

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0001 | Component CCN: 14-5572 | Period: From 07/01/2022 To 06/30/2023 | Worksheet E-1 Part I | Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		646,504		107	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		646,504		107	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		67,317		9	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		713,821		116	7.00

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0001	Period: From 07/01/2022 To 06/30/2023	Worksheet E-1 Part II Date/Time Prepared: 11/30/2023 12:56 pm
	Title XVIII	Hospital	PPS

		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

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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0001 Component CCN: 14-5572	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part VI Date/Time Prepared: 11/30/2023 12:56 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	706,958	1.00
2.00	Routine service other pass through costs	61,685	2.00
3.00	Ancillary service other pass through costs	5,632	3.00
4.00	Subtotal (sum of lines 1 through 3)	774,275	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	47,260	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	727,015	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.98	Recovery of accelerated depreciation.	0	14.98
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	727,015	15.00
15.01	Sequestration adjustment (see instructions)	13,194	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)	0	15.75
16.00	Interim payments	646,504	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	67,317	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

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OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 14-0001	Period: From 07/01/2022 To 06/30/2023	Worksheet E-5 Date/Time Prepared: 11/30/2023 12:56 pm
	Title XVIII		PPS

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

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

Provider CCN: 14-0001

Period: From 07/01/2022 To 06/30/2023

Worksheet G

Date/Time Prepared: 11/30/2023 12:56 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3,720,076	0	0	0	1.00
2.00	Temporary investments	1,611,428	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	36,445,408	0	0	0	4.00
5.00	Other receivable	7,583,976	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-23,619,572	0	0	0	6.00
7.00	Inventory	2,132,951	0	0	0	7.00
8.00	Prepaid expenses	1,720,833	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	386	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	29,595,486	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	9,074,236	0	0	0	12.00
13.00	Land improvements	3,203,718	0	0	0	13.00
14.00	Accumulated depreciation	-2,512,422	0	0	0	14.00
15.00	Buildings	118,214,508	0	0	0	15.00
16.00	Accumulated depreciation	-45,578,750	0	0	0	16.00
17.00	Leasehold improvements	6,629,898	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	1,246,672	0	0	0	19.00
20.00	Accumulated depreciation	-721,647	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	39,892,716	0	0	0	23.00
24.00	Accumulated depreciation	-30,258,015	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	99,190,914	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	130,904,883	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	1,770,653	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	132,675,536	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	261,461,936	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,480,975	0	0	0	37.00
38.00	Salaries, wages, and fees payable	13,793,188	0	0	0	38.00
39.00	Payroll taxes payable	115,202	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	5,858,104	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	24,247,469	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	67,320,344	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	67,320,344	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	91,567,813	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	169,894,123				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)	169,894,123	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	261,461,936	0	0	0	60.00

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STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-1 | Date/Time Prepared: 11/30/2023 12:56 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		154,508,531		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		15,137,537				2.00
3.00	Total (sum of line 1 and line 2)		169,646,068		0		3.00
4.00	INCREAE IN NET ASSETS WITH DONOR RES	248,046		0		0	4.00
5.00	ROUNDING	9		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)		248,055		0		10.00
11.00	Subtotal (line 3 plus line 10)		169,894,123		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		169,894,123		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	INCREAE IN NET ASSETS WITH DONOR RES		0		4.00
5.00	ROUNDING		0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/30/2023 12:56 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	12,418,186		12,418,186	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,137,182		1,137,182	7.00
8.00	NURSING FACILITY	1,042,154		1,042,154	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	14,597,522		14,597,522	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	5,238,075		5,238,075	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)	5,238,075		5,238,075	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	19,835,597		19,835,597	17.00
18.00	Ancillary services	36,204,779	140,819,068	177,023,847	18.00
19.00	Outpatient services	7,177,129	37,606,285	44,783,414	19.00
20.00	RURAL HEALTH CLINIC	0	25,468,092	25,468,092	20.00
20.01	ELMWOOD RHC	0	863,288	863,288	20.01
20.02	WILLIAMSFIELD RHC	0	74,231	74,231	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	DURABLE MEDICAL EQUIP - RENTED	0	4,140,892	4,140,892	27.00
27.01	PROFESSIONAL FEES	1,782,254	11,579,564	13,361,818	27.01
27.02	LAB GROSS-UP	0	0	0	27.02
27.03	SCHOOL OF NURSING	0	330,673	330,673	27.03
27.04	DIETARY	0	676,252	676,252	27.04
27.05	NON-RHC	0	127,965	127,965	27.05
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	64,999,759	221,686,310	286,686,069	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		109,947,741		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)		109,947,741		43.00

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STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0001 | Period: From 07/01/2022 To 06/30/2023 | Worksheet G-3 | Date/Time Prepared: 11/30/2023 12:56 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	286,686,069	1.00
2.00	Less contractual allowances and discounts on patients' accounts	181,649,498	2.00
3.00	Net patient revenues (line 1 minus line 2)	105,036,571	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	109,947,741	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,911,170	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	2,764,474	6.00
7.00	Income from investments	4,171,203	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	424,080	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	77,692	17.00
18.00	Revenue from sale of medical records and abstracts	5,622	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	1,349,161	24.00
24.01	340B RETAIL PHARMACY	4,323,378	24.01
24.02	CHANGE IN FV OF INTEREST RATE SWAP	967,796	24.02
24.03	UNREALIZED GAIN ON INVESTMENTS	5,965,301	24.03
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	20,048,707	25.00
26.00	Total (line 5 plus line 25)	15,137,537	26.00
27.00	CHANGE IN FV OF INTERST RATE SWAP	0	27.00
27.01	LOSS ON DISPOSAL	0	27.01
27.02	UNREALIZED LOSS ON INVESTMENTS	0	27.02
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)	15,137,537	29.00

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CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0001	Period: From 07/01/2022 To 06/30/2023	Worksheet L Parts I-III Date/Time Prepared: 11/30/2023 12:56 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	396,051	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	2,217	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	17.55	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	398,268	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

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ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0001
Component CCN: 14-3493

Period: From 07/01/2022 To 06/30/2023

Worksheet M-1
Date/Time Prepared: 11/30/2023 12:56 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	4,022,650	8,895,134	12,917,784	-1,132,334	11,785,450	1.00
2.00	Physician Assistant	643,664	0	643,664	-150,704	492,960	2.00
3.00	Nurse Practitioner	2,728,616	0	2,728,616	-648,314	2,080,302	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	3,571,337	0	3,571,337	-536,519	3,034,818	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	35,803	0	35,803	0	35,803	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)	11,002,070	8,895,134	19,897,204	-2,467,871	17,429,333	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	286,620	286,620	-19,666	266,954	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	1,527,696	1,527,696	-104,820	1,422,876	18.00
19.00	Other Health Care Costs	206,221	113,986	320,207	-38,801	281,406	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	206,221	1,928,302	2,134,523	-163,287	1,971,236	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	11,208,291	10,823,436	22,031,727	-2,631,158	19,400,569	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	11,767	0	11,767	0	11,767	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)	11,767	0	11,767	0	11,767	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	33,451	33,451	49,136	82,587	29.00
30.00	Administrative Costs	2,424,074	123,511	2,547,585	-372,641	2,174,944	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	2,424,074	156,962	2,581,036	-323,505	2,257,531	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	13,644,132	10,980,398	24,624,530	-2,954,663	21,669,867	32.00

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ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0001
Component CCN: 14-3493

Period: From 07/01/2022 To 06/30/2023

Worksheet M-1
Date/Time Prepared: 11/30/2023 12:56 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	11,785,450		1.00
2.00	Physician Assistant	0	492,960		2.00
3.00	Nurse Practitioner	0	2,080,302		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	3,034,818		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	35,803		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	17,429,333		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	266,954		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	1,422,876		18.00
19.00	Other Health Care Costs	0	281,406		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,971,236		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	19,400,569		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	11,767		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	11,767		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	82,587		29.00
30.00	Administrative Costs	-476,563	1,698,381		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-476,563	1,780,968		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-476,563	21,193,304		32.00

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ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0001
Component CCN: 14-8603

Period: From 07/01/2022 To 06/30/2023

Worksheet M-1

Date/Time Prepared: 11/30/2023 12:56 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	-402	0	-402	834,257	833,855	1.00
2.00	Physician Assistant	0	0	0	1,435	1,435	2.00
3.00	Nurse Practitioner	-136	0	-136	88,656	88,520	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	111,470	111,470	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	-538	0	-538	1,035,818	1,035,280	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	15,167	15,167	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	80,841	80,841	18.00
19.00	Other Health Care Costs	0	0	0	12,468	12,468	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	108,476	108,476	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-538	0	-538	1,144,294	1,143,756	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	538	0	538	0	538	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)	538	0	538	0	538	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	4,692	4,692	29.00
30.00	Administrative Costs	0	0	0	82,197	82,197	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	86,889	86,889	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	0	0	1,231,183	1,231,183	32.00

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ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0001 | Component CCN: 14-8603 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-1 | Date/Time Prepared: 11/30/2023 12:56 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	833,855		1.00
2.00	Physician Assistant	0	1,435		2.00
3.00	Nurse Practitioner	0	88,520		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	111,470		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,035,280		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	15,167		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	80,841		18.00
19.00	Other Health Care Costs	0	12,468		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	108,476		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,143,756		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	538		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	538		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	4,692		29.00
30.00	Administrative Costs	0	82,197		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	86,889		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,231,183		32.00

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ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0001
Component CCN: 14-8636

Period: From 07/01/2022 To 06/30/2023

Worksheet M-1

Date/Time Prepared: 11/30/2023 12:56 pm

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	90,962	90,962	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	9,888	9,888	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	12,025	12,025	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	112,875	112,875	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	1,652	1,652	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	8,803	8,803	18.00
19.00	Other Health Care Costs	0	0	0	1,351	1,351	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	11,806	11,806	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	0	0	124,681	124,681	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	512	512	29.00
30.00	Administrative Costs	0	0	0	8,874	8,874	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	9,386	9,386	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	0	0	134,067	134,067	32.00

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ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0001
Component CCN: 14-8636
Period: From 07/01/2022 To 06/30/2023
Worksheet M-1
Date/Time Prepared: 11/30/2023 12:56 pm

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	90,962		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	9,888		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	12,025		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	112,875		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	1,652		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	8,803		18.00
19.00	Other Health Care Costs	0	1,351		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	11,806		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	124,681		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	512		29.00
30.00	Administrative Costs	0	8,874		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	9,386		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	134,067		32.00

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ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0001
Component CCN: 14-3493

Period:
From 07/01/2022
To 06/30/2023

Worksheet M-2

Date/Time Prepared:
11/30/2023 12:56 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	16.06	58,822	4,200	67,452		1.00
2.00	Physician Assistant	2.73	34,527	2,100	5,733		2.00
3.00	Nurse Practitioner	14.26	6,882	2,100	29,946		3.00
4.00	Subtotal (sum of lines 1 through 3)	33.05	100,231		103,131	103,131	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	0.40	680			680	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)	33.45	100,911			103,811	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)					19,400,569	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					11,767	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					19,412,336	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999394	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,780,968	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					11,551,972	15.00
16.00	Total overhead (sum of lines 14 and 15)					13,332,940	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					13,332,940	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					13,324,860	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					32,725,429	20.00

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ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0001
Component CCN: 14-8603

Period:
From 07/01/2022
To 06/30/2023

Worksheet M-2

Date/Time Prepared:
11/30/2023 12:56 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	0.64	1,860	4,200	2,688		1.00
2.00	Physician Assistant	0.01	10	2,100	21		2.00
3.00	Nurse Practitioner	1.48	3,789	2,100	3,108		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.13	5,659		5,817	5,817	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.13	5,659			5,817	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,143,756	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					538	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,144,294	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999530	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					86,889	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					630,393	15.00
16.00	Total overhead (sum of lines 14 and 15)					717,282	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					717,282	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					716,945	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,860,701	20.00

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ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0001
Component CCN: 14-8636

Period:
From 07/01/2022
To 06/30/2023

Worksheet M-2

Date/Time Prepared:
11/30/2023 12:56 pm

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.19	913	4,200	798		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.44	981	2,100	924		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.63	1,894		1,722	1,894	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.63	1,894			1,894	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)					124,681	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					124,681	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					9,386	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					81,292	15.00
16.00	Total overhead (sum of lines 14 and 15)					90,678	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					90,678	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					90,678	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					215,359	20.00

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0001 Component CCN: 14-3493	Period: From 07/01/2022 To 06/30/2023	Worksheet M-3 Date/Time Prepared: 11/30/2023 12:56 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)			32,725,429	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			724,327	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			32,001,102	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			103,811	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)			103,811	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			308.26	7.00
		Calculation of Limit (1)			
		Rate Period 1 (07/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 06/30/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	260.97	270.88		8.00
9.00	Rate for Program covered visits (see instructions)	260.97	270.88		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	8,128	7,996		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	2,121,164	2,165,956		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	42		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	11,377		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	11,377		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	4,298,497		16.00
16.01	Total program charges (see instructions)(from contractor's records)		2,241,436		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		156,096		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		299,352		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.)		3,001,532		16.04
16.05	Total program cost (see instructions)	0	3,300,884		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		247,230		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		396,618		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		3,300,884		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		118,740		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		3,419,624		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)		3,419,624		26.00
26.01	Sequestration adjustment (see instructions)		68,392		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		3,187,414		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)		163,818		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0001 Component CCN: 14-8603	Period: From 07/01/2022 To 06/30/2023	Worksheet M-3 Date/Time Prepared: 11/30/2023 12:56 pm
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,860,701	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		38,909	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,821,792	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		5,817	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		5,817	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		313.18	7.00

		Calculation of Limit (1)		
		Rate Period 1 (07/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 06/30/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	270.69	280.97	8.00
9.00	Rate for Program covered visits (see instructions)	270.69	280.97	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	387	382	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	104,757	107,331	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	1	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	281	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	281	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	212,369	16.00
16.01	Total program charges (see instructions)(from contractor's records)		98,371	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		7,848	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		16,943	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.)		140,923	16.04
16.05	Total program cost (see instructions)	0	157,866	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		19,272	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		15,806	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		157,866	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		11,541	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		169,407	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)		169,407	26.00
26.01	Sequestration adjustment (see instructions)		3,388	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		135,700	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)		30,319	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0001 Component CCN: 14-8636	Period: From 07/01/2022 To 06/30/2023	Worksheet M-3 Date/Time Prepared: 11/30/2023 12:56 pm
	Title XVIII	RHC III	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		215,359	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		11,136	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		204,223	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,894	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)		1,894	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		107.83	7.00

		Calculation of Limit (1)		
		Rate Period 1 (07/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 06/30/2023)	
		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)	107.83	107.83	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	0	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		0	16.04
16.05	Total program cost (see instructions)	0	0	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		0	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,198	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		2,198	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)		2,198	26.00
26.01	Sequestration adjustment (see instructions)		44	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		0	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)		2,154	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

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COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0001 Component CCN: 14-3493 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-4 Date/Time Prepared: 11/30/2023 12:56 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)	17,429,333	17,429,333	17,429,333	17,429,333	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001071	0.001818	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	18,667	31,687	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	332,028	47,013	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	350,695	78,700	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	19,400,569	19,400,569	19,400,569	19,400,569	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	13,324,860	13,324,860	13,324,860	13,324,860	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.018077	0.004057	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	240,873	54,059	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	591,568	132,759	0	0	10.00
11.00	Total number of injections/infusions (from your records)	1,513	2,569	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	390.99	51.68	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	215	671	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)	84,063	34,677	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)		724,327	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)		118,740	16.00

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COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0001 Component CCN: 14-8603 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-4 Date/Time Prepared: 11/30/2023 12:56 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)	1,035,280	1,035,280	1,035,280	1,035,280	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000845	0.002234	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	875	2,313	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	17,051	3,678	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	17,926	5,991	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,143,756	1,143,756	1,143,756	1,143,756	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	716,945	716,945	716,945	716,945	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.015673	0.005238	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	11,237	3,755	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	29,163	9,746	0	0	10.00
11.00	Total number of injections/infusions (from your records)	76	201	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	383.72	48.49	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	23	56	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)	8,826	2,715	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)		38,909	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)		11,541	16.00

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COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-0001 Component CCN: 14-8636 | Period: From 07/01/2022 To 06/30/2023 | Worksheet M-4 Date/Time Prepared: 11/30/2023 12:56 pm

Title XVIII | RHC III | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	112,875	112,875	112,875	112,875	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000790	0.002746	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	89	310	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	4,712	1,336	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4,801	1,646	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	124,681	124,681	124,681	124,681	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	90,678	90,678	90,678	90,678	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.038506	0.013202	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,492	1,197	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	8,293	2,843	0	0	10.00
11.00	Total number of injections/infusions (from your records)	21	73	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	394.90	38.95	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	3	26	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1,185	1,013	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)		11,136	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		2,198	16.00

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ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0001 Component CCN: 14-3493	Period: From 07/01/2022 To 06/30/2023	Worksheet M-5 Date/Time Prepared: 11/30/2023 12:56 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		3,187,414	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)		3,187,414	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		163,818	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		3,351,232	7.00

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

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

Provider CCN: 14-0001
Component CCN: 14-8603

Period: From 07/01/2022 To 06/30/2023

Worksheet M-5

Date/Time Prepared: 11/30/2023 12:56 pm

RHC II | Cost

		Part B mm/dd/yyyy 1.00	Part B Amount 2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		135,700	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)		135,700	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		30,319	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		166,019	7.00

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

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

Provider CCN: 14-0001
Component CCN: 14-8636

Period: From 07/01/2022 To 06/30/2023

Worksheet M-5

Date/Time Prepared: 11/30/2023 12:56 pm

RHC III | Cost

		Part B mm/dd/yyyy 1.00	Part B Amount 2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		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	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)		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			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		2,154	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		2,154	7.00

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